

THE
NATION
1865 Centennial Year 1965

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**DOCTORS,
PATIENTS AND
SOCIETY**

The Conflict in Goals

Selig Greenberg

Elton Rayack

Stanley Meisler

George A. Silver

GROWING UP ITALIAN

A Review by Luigi Barzini

Upsala College
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East Orange, N. J.

LETTERS

Sartre and the sheep

Boston, Mass.

Dear Sirs: Sartre is completely right both in his refusal to visit the U.S. and in his analysis [*The Nation*, Apr. 19]; it is not that he has misread American opinion but rather that *The Nation* has. . . . You say one-third of the Senate is critical of Vietnam. The Senate, with the exception of two men, acts like a herd of sheep. The President's speech, with its historic misconceptions, was one of fulsome reasoning; it is indecent to offer to rebuild what one daily destroys. . . .

Florian Weissenborn

La Habra, Calif.

Dear Sirs: There is one aspect of the Sartre matter which has not been brought out, although I doubt that M. Sartre really overlooked it, and only "modesty" on his part kept him from including it—that his cancellation of his visit could be a far greater instrument for the continuance of "dialogue" than a quiescent visit. . . .

Martha N. Smith

Cedar Rapids, Ia.

Dear Sirs: The fault in your criticism of Sartre is that you do not seriously and urgently face his criticism. Sartre says that the way to make Americans sensitive to the American threat of world war in Vietnam is to condemn the cynical and brutal American imperialism there, and to get others to do so. Having said that, what more can Sartre say? . . . To debate that we should sit in an auditorium and listen to the Great Existentialist robs us of our own resistive power. It diverts us from the issue. . . . The thing is to act—now—and not to listen to a foreign philosopher say things we already know. The thing is to mount a massive resistance to U.S. imperialism and World War III.

Howard L. Parsons

The message

Woodland, Calif.

Dear Sirs: President Johnson at Johns Hopkins University: "I wish it were possible to convince others with words of what we now find it necessary to say with guns."

General Sadao Araki, in anticipation of Japan's occupation of Manchuria in 1931: "We are exceedingly sorry that China does not yet understand the sincerity of Japan. It is the Japanese mission to struggle against all acts incompatible with Imperial virtue. . . . Japan has no other intentions than to realize, with all its power, the fundamental ideal—the preservation of peace." Ernest T. Nash

Exaggerated difference

St. Petersburg, Fla.

Dear Sirs: Much of what Walter Lippmann wrote in his recent *Herald Tribune* column about Bonn's Hallstein Doctrine, that is, the West German Government's refusal to recognize any government which establishes diplomatic relations with the German Democratic Republic, is true. This certainly represents unreality, as Mr. Lippmann points out, for the GDR does exist and is doing a flourishing business with many countries—actually 100 countries. The Hallstein Doctrine actually finds its counterpart in the United States Government attitude toward Red China.

What disturbs me about the Lippmann article is his description of the two German governments. He writes, "One is the liberal and Democratic Federal Republic with its capital in Bonn. The other is a totalitarian Communist government in Pankow in East Berlin." I have lived in Germany on three different occasions for a total of more than three years. I have traveled over both Germanys many times and extensively, most recently in 1962.

This statement of Mr. Lippmann is not only a serious oversimplification of the true conditions in the two states but a great exaggeration of these conditions. The West German Government is neither liberal nor democratic. . . . The people in West Germany had nothing to do with the formation of this government and they have had nothing to do with its composition at any time above the local level. . . .

And the East German Government is neither totalitarian nor Communist. It is not even a Socialist government at this point, for the private sector of business and industry is still quite large. (I investigated this thoroughly in 1962.) On the local and regional level there is extensive participation by the people. This even extends to the national level on most domestic issues. There are several major parties participating in the National Parliament. . . .

The German Democratic Republic is the fifth industrial power in Europe and the tenth in the world. Furthermore, it is the only German govern-

Correction

Last week's editorial, "The Technological Dilemma," should have made clear that the branch of the School of Medicine of the State University of New York mentioned is the one situated at Buffalo.

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ment in more than a hundred years that has wanted peace with its neighbors, or believed peace possible.

The United States Government should recognize the German Democratic Republic and do the utmost to promote its policies for a peaceful united Germany.

Hugh B. Hester
Brig. Gen., U.S. Army (Ret.)

The Deepening War

The aerial operation of the United States against North Vietnam has never been more than a diversion from a militarily impossible situation to one which, for a while, could yield some psychological and political dividends. The United States has intervened in a civil war in South Vietnam. Its side has been losing; it has neither a stable government, an aggressive army, nor a sympathetic population. North Vietnam is aiding the winning side, as we are aiding the losing side. For President Johnson and his war-hawk advisers, it became a "do-something" situation. He chose to do the obvious—attack North Vietnam from the air. He tried to limit the extension of the war by denying that it was an extension, and by keeping operations under his own control. Marquis Childs prints without qualification an inside statement that the President controls the whole targeting pattern from the situation room in the White House, thus insuring "restraint that might not be a factor if the Air Force were in direct control of the operation."

But the air operation is not succeeding. Hanoi, the experts say, "hurts" but gives no sign of surrendering. Nor, if Hanoi were inclined to yield, would the Vietcong follow suit; it cannot be too strongly emphasized that the guerrillas are conducting their own war, on their own territory, and will continue to do so with whatever means are available to them. The next move, then, is up to the President and the coterie of which he is both the leader and the servant. Short of making peace, he must intensify the war in the south, and aerial warfare alone cannot serve his purpose there.

The conference of U.S. war leaders in Hawaii discussed a build-up of the South Vietnamese army, now 575,000 strong, by another 160,000 men. This augmentation cannot be done quickly, and the new troops are not apt to be superior to the ones that have been losing to the numerically inferior Vietcong. Aside from the American "advisers" required to train the new levies, battle-ready American divisions will have to be committed to stave off defeat in South Vietnam and to convince the Vietnamese, the Russians and the Chinese that, as the President said, no power on earth can oust the United States from South Vietnam.

Hanson Baldwin, who has been getting hard news from Pentagon sources, estimates in *The New York Times* (April 21) that the Third Marine Division may reinforce the 8,000 to 9,000 Marines already at the Danang air base. This would increase the Marine ground-combat strength in Vietnam to between 20,000 and 30,000 men. It is a safe guess that the Army will not wish to leave ground fighting to the Marines. Elements of one or more Army divisions will be sent in. Soon a hundred thousand American soldiers, more or less,

will be fighting in Vietnam, and at some point, by an accident which may be real or contrived, they are likely to be fighting North Vietnamese, or Chinese, or both. Thus, by a seemingly ineluctable process, the ground war in Asia—from which General Eisenhower, General Ridgeway and almost every other American military leader recoiled—comes nearer, step by step. And, step by step, the control of the man in the White House will grow less.

Diplomacy a la Johnson

By all present indications, Lyndon B. Johnson will go down in history as one of the most forceful of American Presidents. Whether he will be remembered for his tactful diplomacy remains open to doubt.

Among all the human arts, diplomacy is ethically perhaps the most dubious; nevertheless it is an art, with a code, a language and techniques of its own. Mr. Johnson does not seem to understand this, and if anyone has ventured to bring the rules to his attention recent events give little evidence that he has studied them.

It may be that Mr. Johnson honestly believes the methods he employs in dealing with subordinates in the U.S. Executive establishment are applicable in foreign affairs. But there is a difference. Cabinet members, bureaucrats—even the highest—can be fired or neutralized by the President, but foreign potentates are not so easily disposed of. Nor are they Congressmen to be cajoled or chided. Certain pressures can be applied to them, but they serve foreign powers whose capital is not Washington, D.C.

Not that Mr. Johnson is incapable of putting on diplomatic blarney. If the foreigner agrees with U.S. policy, nothing is too good for him. Premier Aldo Moro of Italy has just received the full treatment. Having been attacked by Italian Communists and left-wing Socialists for his endorsement of U.S. policy in Vietnam, he was the recipient of unparalleled Presidential rewards. In addition to the 19-gun salute and the usual homage, he sat in on a Cabinet meeting and heard, even if he could not understand, a discussion on divers topics, including Vietnam.

But what thunders and lightnings descend on the hapless foreigners whose views do not coincide with Mr. Johnson's! Two were drawn and quartered—in a diplomatic sense—in a single execution on April 16. The President announced abruptly that he was not receiving President Mohammed Ayub Khan of Pakistan, due on April 26, or Prime Minister Lal Bahadur Shastri of India, whose audience was set for June. These cancellations may have had nothing to do with Ayub Khan's recent fraternizing with Peking, or Shastri's pleas for a cessation of the bombing of North Vietnam. The only reason may have been the an-

nounced one: that the President is preoccupied with the war, which he is personally directing in Vietnam, and in getting legislation through Congress. Unfortunately, no one conversant with the customs of diplomacy will believe that the stated reason is the real one. It never is.

If Mr. Johnson set out deliberately to chastise the two Asian dignitaries, he was in a sense successful. Mr. Shastri has let it be known that he is furious, while Mr. Ayub Khan, who was cut off on such short notice that he never even had a chance to make another date, is probably in an equally dark mood. He may be contrasting his own manhandling with the kindnesses that Mr. Johnson, as Vice President, showered on one of his subjects, the famed camel driver Bashir Ahmed. Perhaps the situation could be remedied if Mr. Johnson would send Mr. Ayub Khan a 1965 pickup truck. It would be a novel diplomatic gesture, but then Mr. Johnson, who once yelled "Yahoo" in the Taj Mahal to hear the echo, is no slave to tradition.

The Peace Opposition

The word from inside the Administration is that the President, backed by his chief military and diplomatic advisers, looks on the rising peace drive with some alarm because of the encouragement it may be offering to Hanoi. The President, presumably, is sincere in his desire to negotiate a settlement—on terms favorable to the United States. He thinks the peace movement may be deluding Hanoi and its allies into believing that the American will to wage war is flagging. This delusion, the President thinks, may actually prolong the fighting. He would, if anything, prefer to see some demonstrations of bellicosity, though it is not clear how a national cry of "on to Hanoi" would improve the prospects for negotiation. And a substantial voice for peace might well improve the President's ability to maneuver domestically when the opportunity for negotiation arises.

However that may be, Mr. Johnson is currently troubled by the growing protest. He was reported particularly upset by a full-page ad against the war published in *The New York Times* and signed by clergymen of all faiths. And since then, Martin Luther King, whose influence is incalculable, but who has confined his words almost exclusively to civil rights, has told a Boston audience that Negro leaders may well speak out against war, since "peace and human rights are inseparable." Mr. Johnson stands in awe of the nation's spiritual representatives. He also takes careful note of the criticism of the war on Capitol Hill. There is no doubt that the anti-war factions there are becoming not only stronger but less deferential of the President's desire that they stay silent. Representatives of the State Department are now being assigned to campus speaking tours, in an effort to offset (but improbable effect, to invigorate) the student protest typified by "teach-ins" and the Easter march of some 20,000 on Washington. The

President is not challenging the sincerity of the peace seekers; he is simply convinced that they are moving the country in the wrong direction. If he is upset, it is because he believes the clergy have particular ability to sway public opinion, and he knows that Congress can hurt him in a variety of ways. The peace movement may be telling him that the country rejects war, but the President is increasingly irritated because it represents an obstacle to the escalation strategy of achieving peace.

'A National Disgrace'

If there is anywhere in the world a nation more indifferent to its environment than the United States, it must be one that dedicates itself single-mindedly to befouling earth and air and water. Referring to one aspect of this contamination, President Kennedy in 1961 called the pollution of the country's rivers "a national disgrace." Recently President Johnson and Governor Rockefeller have expressed similar sentiments and proposed corrective measures which, if precedent is a guide, will be too little and too late. This is one area, however, in which retribution is automatic. The impending water shortage, when it comes, will be in large part the consequence of profligate pollution and waste.

In the March 2, 1965, *New York Times*, Gladwin Hill described conditions in Georgia. The once-crystalline Chattahoochee River as it flows into Atlanta is the color of coffee with cream from filth discharged upstream. Atlanta then takes the foul mixture and treats it expensively with alum, chlorine, ammonia, carbon and lime to make it usable for domestic and industrial purposes. After passing through 500,000 alimentary canals and the factories of the city, the water is discharged back into the river, even darker in color than before. By the time Atlanta has finished with it, the water is so filthy that it is unfit for use by industry downstream for many miles.

This sort of situation is not unique in the Georgia watersheds, nor is Georgia worse than other states. New York City has acquired at great cost a splendid upland water supply, but it dumps 500 million gallons of raw sewage into the Hudson and East Rivers every day. Last summer there was an outbreak of typhoid fever when some youths ate a watermelon they found floating in the Hudson. Upstream, the Hudson serves as both a sewer and a municipal water supply. Again, this is not atypical. As President Johnson pointed out, every major river system in the United States is polluted, and surface water is the chief source of municipal supply.

Domestic use of water comprises only 6 to 8 per cent of total use; the rest serves agricultural and industrial interests. Industry is a major source of trouble. One index of stream pollution is the number of fish that are killed. The U.S. Public Health Service found that in thirty-six states during a seven-month period, out of 6.3 million fish killed by pollution, industrial wastes accounted for some 5.5 million. Industry has

been under pressure to control its pollution loads, and the National Association of Manufacturers reports that companies now spend \$100 million a year to combat pollution. Compared with the value of the goods produced this is still a trifle and, as the effluent from many industrial plants proves, not nearly enough. Moreover, the cost of waste-treatment facilities is largely offset by lowered cleanup expense downstream.

In an article in the April *Fortune*, "Water Shortage Is a Frame of Mind," William Bowen calls attention to the Ruhr River basin. It contains some 40 per cent of West Germany's industrial capacity and enjoys very little stream flow, yet the water is potable with only moderate treatment. A system of semi-governmental organizations levies on every municipality and every industrial plant a charge proportionate to the pollution load in the effluent, scientifically measured.

Under the best of circumstances we shall have to spend billions of dollars for water storage and transportation to areas of scarcity. Coordinate with this investment we should stop misusing the water we already have. There is a great deal of it, if we treat it with ordinary decency.

Physicians as Activists

Soon the great summer holiday weekends will be upon us—Memorial Day, Independence Day, Labor Day. Even on ordinary weekends millions of motorists take to the roads, on pleasure bent. A sizable number are going to their own funerals, or to a lifetime of disability.

A few critics, to be sure, argue vocally that Detroit is not doing all it could to make cars safe, but the auto industry's advertising budgets and public relations being what they are, Detroit is not unduly worried and continues to stress power, luxury and style. The International Automobile Show at the Coliseum in New York drew an attendance of 493,500, and floor sales amounted to \$150,000,000. Yet an unscheduled feature of the show should shake the auto magnates' *sung-froid*. Outside there was a picket line of M.D.s—representatives of Physicians for Automobile Safety—who devoted a few hours stolen from practice to something equally important. Dr. Seymour Charles, a Newark, N.J., pediatrician and president of the group, was on the line; another demonstrator was the vice president, Dr. Leo Mayer, a Park Avenue orthopedic surgeon. The members cover a wide range of specialties and general practice: neuro-surgeons, pediatricians, plastic surgeons, et al. They, and other physicians, have one thing in common: they not only read the automobile-accident statistics in the papers but they see the dead and the dying and the injured at the scene, or try to restore function and appearance to mutilated bodies afterwards.

The medical profession as a whole, and the American Medical Association and its *Journal*, have been commendably active in focusing automotive-accident prevention on the automobile itself. This is only one aspect of the problem, but it is the one in which

most progress can be made. Medically, human accidents may be regarded as a disease of epidemic proportions, the leading cause of death among Americans under 25, with traffic accidents of major importance in the teen-age and early-twenties groups. The epidemic involves "hosts," the men, women and children who ride in cars; an "environment," the highway; and an "agent," the vehicle. The auto industry's stand is that the chief trouble is with the drivers and that safety will not sell cars. As Sen. Gaylord Nelson puts it, "It is the stylist who reigns supreme in the automobile industry, not the safety and engineering experts."

The movement on the part of the medical profession will eventually put a dent in this self-seeking line of reasoning. "Human lives are at stake, not balance sheets," Dr. Charles points out. There are some highly intelligent executives in automobile manufacturing. If they will listen to the doctors, they will forestall a great deal of difficulty for their industry.

The White Russian Bear

An effective *rapprochement* between Soviet Russia and the United States may be ushered in by the polar bear. The polar bear is virtually stateless—neither Communist nor democratic, it is merely polar. What it chiefly inhabits is the ice pack in the Arctic Ocean, straying sometimes to Alaska, Canada, Greenland, Scandinavia and Soviet Russia. There is an unsubstantiated theory that some bears migrate right around the Pole, through all jurisdictions, but this one-world proclivity has not been proved. Certainly the white bears are mobile, for they have been seen swimming or floating out at sea 80 miles from land or ice.

The polar bear has a large brain case and is a very clever animal. It can detect man several miles away. But it cannot contend with hunters in airplanes, and so it is down to a world population of approximately 10,000 individuals.

The Russians are concerned about the white bears, and so are we. In 1956, Russia imposed severe restrictions on hunting the species, but some twenty to forty live cubs are taken for zoos each year. Wrangel Island has been declared a temporary sanctuary and the bears are strictly protected. In Alaska, residents may take bears without limit for food, but must not use planes. Licensed hunters may take one animal by aircraft. In Canada, only Eskimos and Indians may hunt the polar bear.

Recently, Sen. E. L. Bartlett of Alaska proposed the calling of an international technical meeting composed of the eight interested nations to pool knowledge of the bears and agree on a code of protection. It seems likely the meeting will be called next September, and so far the Russians are agreeable.

If the arctic, the white bears' country, should be the no-man's land of any major atomic war, we ought surely to know everything possible of these neutrals, whose whole conformation and way of life are an adaptation to the cold war.

Doctors, Patients & Society

One need not apologize for repeating the truism that health is precious. As precious as the defense of the state? Will the Great Society be realized without serious attention to the provision of full modern health services to every member of that society? Yet the values of the market place still guide medical care in the United States. Income determines access to service, quality is juggled at the patient's expense and advertising slogans replace standards in product performance.

The four papers that follow pursue somewhat different lines of approach, only to end with the same question: How long will the American people permit themselves to be deprived of the fruits of modern medical knowledge? With our wealth and resources, how long will we remain short of needed doctors and other health personnel, of modern facilities, of access to modern medical care? How long must we be subjected to the erratic and capricious vagaries of a disorganized

and inadequately financed medical-care system?

There is no lack of knowledge as to how a rational, nationally financed medical-care system could be organized. There is no dearth of methodological information on how to provide needed numbers and needed quality of personnel and facilities. It would seem that health is too important to be left to the doctors. In this instance, the patient had better prescribe for himself.—

The Editors

Practice and Malpractice Selig Greenberg

The proud boast of the defenders of the *status quo* in medicine is that Americans are enjoying "the best medical care in the world." This is the sort of bombastic generalization that has just enough truth in it to sound plausible, but which withers under examination. It deliberately ducks the question as to how prevalent and accessible is the "best" care.

The best medical care in the United States is probably unexcelled anywhere else in the world. But there is considerable evidence that much of the care Americans are getting is mediocre and that some of it is atrocious. Since under our notoriously flaccid system of professional regulation a doctor is, in essence, answerable to nothing but his own conscience, performance fluctuates from superb craftsmanship and bounteous dedication to gross incompetence and outright venality. Free enterprise in medicine may have its advantages, but it also means the freedom to be inadequate and to get away with it, especially since the average layman has no reliable criteria for assessing a doctor's competence.

Few bromides in the dogma of organized medicine are more sacred than the "free choice" of doctor, an emotion-drenched concept held to

be indispensable to rapport between physician and patient and to high standards of medical care. Actually, the slogan is little more than a smoke screen for laissez-faire anarchy in the medical market. What the consumer needs to replace the present haphazard selection of physicians is help in making an enlightened choice.

The problem of the quality of health care has been enormously aggravated by the steadily growing complexity of medicine and by the average busy practitioner's difficulties in keeping abreast of medical progress. While the organized profession puts up a front of platitudes for the lay public, physicians are sometimes quite outspoken within the "family" about the shortcomings of their craft. The professional journals not infrequently carry documented reports of slapdash and shoddy performance, of glaring errors in diagnosis and treatment, of the scandalous degree to which drug company salesmen and promotional material have taken over the postgraduate education of doctors, and of such evils as kickbacks, fee splitting, ghost surgery and unnecessary surgery.

Informed opinion is that thousands of physicians continue to treat diseases and organic conditions that are far beyond their professional competence, that the benefits of good medical care are not equally available to all, that a tremendous challenge is posed by the wide variations in health from one

individual to another and from one group to another, and that the nation's overall health record leaves plenty of room for improvement.

The most valid test of the adequacy of our medical services is not that the health of Americans is better than it was a generation ago or a century ago or that it is better than in some other countries. The real test is whether we are using the tools placed at our command by the remarkable advances of medical science as well and as effectively as we know how.

However, the allegation that our medical care is unequalled anywhere else runs smack into the fact that a number of countries with poorer economic resources than ours consistently outrank us in some of the most dependable measurements of health status. Infant mortality has always been considered the most accurate index of a nation's progress in the health field. Ten countries have a lower infant death rate than the United States. The rate for Sweden, the lowest, amounts to less than 60 per cent of ours. Sweden also has a mortality rate among mothers in childbirth that is nearly 15 per cent lower than in this country and an average life expectancy that is three years longer. In ten other nations there is also a higher life expectancy at birth than in the United States. In the Netherlands, the general death rate is 20 per cent lower for men and 10 per cent lower for women than ours. Comparative studies

Selig Greenberg, winner of two medical journalism awards from the Lasker Foundation, is the author of *The Troubled Calling: Crisis in the Medical Establishment*, to be published by Macmillan in June.

show that the physical fitness of our young people is well below that of European children measured by the same standards.

Disturbing as these disparities between the United States and some other countries are, there is ground for even greater concern in the sharp differentials in health conditions, and particularly in maternal and infant mortality, between our richer and poorer citizens and states. Negroes have always had much higher rates of illness and death than their white neighbors. While considerable progress in improving health conditions among nonwhites has been made in recent years, life expectancy at birth for Negro men is still 6.4 years under that for white males, while in the case of women the difference is 7.7 years.

The Negro maternal mortality rate is nearly four times as high as that for whites, and the infant death rate is almost twice as high. Although Negroes make up only 10.5 per cent of the population, they account for more than 40 per cent of the annual toll of life among mothers in childbirth. Mississippi still has 8.3 maternal deaths for each 10,000 live births as compared with only 1.7 for Massachusetts. The same two states have respectively 39 and 22.3 deaths among babies under 1 year of age, per 1,000 live births.

Poverty is invariably accompanied by a higher incidence of illness and higher death rates. Although the low-income groups need the most medical care, they usually get the least. The tragedy is that millions of Americans meet the problem of medical costs by seeing a doctor as rarely as possible and by neglecting early symptoms of ill health, with the result that diseases which might have been prevented or controlled if they had been detected at the outset are sometimes permitted to develop into irreparable calamities.

But even those who can manage to pay for their medical care are not infrequently victimized by hasty treatment and by physicians who are incompetent or unscrupulous or both. In a system where it is not uncommon for doctors to see as many as thirty to forty patients a day, there is inevitably much superficial care and a tendency toward promiscuous overmedication on the basis of symptoms rather than pre-



Keystone

Fleming Window, St. James Church, London

scriptions only after careful diagnosis. Despite all the advances of medicine, a complete physical examination and an accurate medical history of the patient remain the best means of arriving at a correct diagnosis. But since these essential procedures are time-consuming, many physicians resort to symptomatic treatment. They listen to enough of the patient's story to make a show of interest, go through some of the motions of a physical examination, and prescribe largely on the basis of obvious symptoms.

Under our appallingly weak system of professional regulation, minor punishment, or none at all, is handed out to mentally sluggish, careless, inept or dishonest physicians—the practitioners who frequently make the wrong diagnoses, use outmoded or worthless treatments, prescribe the wrong drugs, refuse to visit seriously ill patients, bungle operations for which they are not trained, perform unnecessary surgery, charge exorbitant fees,

split fees to get business, and cheat on health and other insurance. Sick people are particularly vulnerable to exploitation and peculiarly ill-equipped to appraise the doctor's performance.

Among a number of studies which in recent years have shed light on the extent of poor medicine in the United States, those made in North Carolina and in New York are outstanding.

In the North Carolina investigation, sponsored by the Rockefeller Foundation, eighty-eight practitioners picked at random were subjected to intensive observation by teams of specialists throughout the daily routines in their offices, on hospital rounds and on house calls. The findings are a devastating commentary on American general practice.

The investigators reported "tremendous variations in the quality of medical care" and an astonishing percentage of inferior performance. They found that the inadequate doctors, who made up nearly half of the total, "practiced from

their desk chairs. Histories were almost nonexistent, and the few questions asked were often irrelevant. Patients were seldom undressed or laid down for examination. Abdominal examinations were performed with patients sitting in a chair."

In 43 per cent of the cases, the doctors under study used improperly sterilized instruments in giving hypodermic injections, with the consequent hazard of serum jaundice. "The same instrument," it was reported, "was sometimes used repeatedly for successive patients, and inadequate sterilization was done between each use. An occasional physician used sterile instruments with unwashed hands, while others failed to wash their hands after obvious or presumptive contamination."

The observers discovered that even when the North Carolina doctors saw new patients, "complete head-to-toe examination was the exception rather than the rule." In 45 per cent of the cases, examinations were performed with the patient fully or almost completely dressed. In 60 per cent, tapping of the chest, one of the basic procedures in medical examination, was not done at all, despite the fact that many of the patients were suffering from respiratory infections. In another 17 per cent, the chest was "thumped perfunctorily." In 86 per cent of the cases, the breasts of women patients were not even "routinely examined."

Essential laboratory procedures also were frequently neglected. There was a high proportion of hasty and wrong diagnoses, dan-

gerous symptoms were frequently overlooked, and the "indiscriminate" use of antibiotics and "shotgun preparations" was commonplace.

The report emphasized that the physicians whose work was studied appeared to be typical of the run of general practitioners. "The training taken by these doctors," it said, "is similar to the training in a wide variety of hospitals in all parts of the United States. The physicians studied came from many medical schools and had exhibited all degrees of academic success, so there is no reason to assume an adverse selection. It can therefore be stated with considerable assurance that in terms of medical education and training the physicians who participated in this study are not evidently different from general practitioners at large."

Equally shocking conditions were revealed in a study of medical records covering more than 400 cases of hospitalization by members of the Teamsters' union and their families in New York City. The panel of specialists who made the study for Columbia University's School of Public Health and Administrative Medicine reported that one-fifth of the patients had received "poor care" and another fifth only "fair care." One-fifth of the hospital admissions were held to have been completely unnecessary. The quality of surgery was labeled "poor" in 20 per cent of the cases.

The specialists held that at least twenty of sixty hysterectomies (removal of the womb) were unnecessary and the advisability of six

others was questionable. Of thirteen Caesarean sections performed, there was a "serious question" about the need for seven. Regarding one case in which an outmoded type of Caesarean operation was performed, one of the surveying specialists declared: "This is the worst case I ever saw. The two doctors [who performed the operation] should be castigated." In another instance, a surgeon was accused of making "a mountain" out of the routine removal of a small vaginal cyst by an unnecessary incision through the flank. In the process, he also removed the woman's perfectly normal appendix. And to top it off, he refused to permit her discharge from the hospital until his \$450 bill had been paid. The report described the duration of the hospital stay in this case as "scandalous."

"Essentially, there were two causes for care that was judged to be inferior," the report stated. "One was related to surgery performed on essentially normal organs, where the grave suspicion of patient exploitation could be raised. The other factor, equally discouraging in a city that has such a large number of fine hospitals and a high proportion of well-trained physicians, was inferior care resulting from poor clinical judgment on the part of a certain number of physicians without either adequate training or supervision."

If poor medicine is so common in New York City, with its concentration of excellent teaching hospitals affiliated with some of the nation's best medical schools, one must wonder what the situation is in hundreds of smaller communities with insufficient medical facilities and many isolated and inadequately trained doctors.

Further indications of widespread abuses in the lucrative field of surgery come from comparisons of surgical rates for those who have health-insurance coverage and those who have none. A Health Information Foundation survey has found that the surgical rate for the insured is nearly double that of the uninsured. Some of this discrepancy is understandable. While those who cannot afford insurance coverage usually wait until operations can no longer be averted, the insured are apt to have an appreciable proportion of elective surgery. But the factor of fees guaranteed by insur-



Clinic

Peggy Bacon: Downtown

ance cannot be overlooked. The placing of insurance price tags on practically any organ in the body that can be shaken loose sometimes leads to flagrant transgressions of medical ethics.

The Health Information Foundation study discovered that while only five out of every 1,000 uninsured persons have their appendixes removed every year, the annual appendectomy rate for the insured is eleven per 1,000. The big difference cannot possibly be attributed to medical reasons alone. If it were, the death rate from ruptured appendixes among those without health insurance would be appalling.

Significantly, the Welfare and Retirement Fund of the United Mine Workers of America managed to slash the rate of appendectomies for its beneficiaries by 59.4 per cent after it set up its own group-practice teams of salaried doctors. No wonder that "chronic remunerative appendicitis" is a standard quip among physicians.

Equally open to question is the

differential in the tonsillectomy rate. Hospitalization rates for children up to the age of 17 for tonsillectomies are 30 per 1,000 for insured families as compared with only 9 per 1,000 for the uninsured.

The sharply higher tonsillectomy rate among the insured is particularly deplorable in view of the fact that the value of this operation and of surgery for the removal of adenoids in children is seriously questioned by reputable medical authorities, except in a restricted number of cases in which certain special conditions exist. Respiratory diseases decline as youngsters grow older, and the drop has been found to be exactly the same in children who did and in those who did not have their tonsils and adenoids removed.

A study made by Dr. Osler L. Peterson of Harvard Medical School shows that, while one Blue Cross plan in the United States has a rate of 12.3 hospital admissions for tonsils and adenoids per 1,000 subscribers, the rates for such admissions are only 3.6 per 1,000 persons in

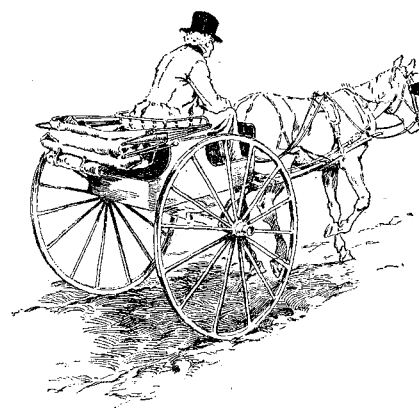
England and 0.25 per 1,000 in Sweden. "Since the diagnostic criteria of what constitutes a diseased tonsil are notably fallible and the results of tonsillectomy-adenoidectomy performed as a treatment for repeated respiratory infections are very debatable," Dr. Peterson has said, "I believe that the lower rates of Sweden and England represent more discriminating use of this operation." It is lamentable that the natural inclination of many surgeons to rush their patients into the operating room should be spurred by the bait of insurance payments.

It is hardly accidental that the prevalence of bungling diagnosis, hasty and sloppy treatment and questionable surgery has been accompanied by a phenomenal increase in malpractice suits. Estimates are that the number of damage suits has increased twenty-five-fold since the end of World War II, and that physicians now are paying some \$50 million a year in court awards and out-of-court settlements.

(Continued on page 488)

Education: The Forgotten Patient George A. Silver, M.D.

Lester Evans, a distinguished American physician who was associated for many years with the Commonwealth Fund in its efforts to improve medical practice and medical education, has put together a group of his lectures delivered at the University of Michigan.* These relate to problems of medical education with particular reference to the preparation of doctors for their social role. Since he has aimed at a university audience and deliberately focused narrowly on the interaction of university education and preparation for medicine, Dr. Evans cannot be too severely criticized for what he has omitted from consideration. The "Crisis" which he discusses at length, and with the depth of knowledge and experience he gained in thirty years with the Commonwealth Fund, is that present methods of selecting students, emphasis in curriculum content, and organization of medical education are completely inadequate to



prepare the physician for the role he is to play in the community.

These essays represent in words what Dr. Evans has tried to accomplish in deeds throughout his professional life. During his tenure in office, the Commonwealth Fund provided the seed money out of which grew such important teaching experiments as the Comprehensive Care and Teaching Program at Cornell and similar programs at the University of Colorado, Western Reserve University, the University of Pennsylvania and others.

Many of the young men who are now leading the efforts to develop new, different and, one hopes, better procedures for medical education were trained in Commonwealth-supported programs and some hold positions supported by Commonwealth grants.

However, recognizing this should not lead one to assume that the solutions to current problems with regard to medical care in the United States will be found in this little monograph. After all, it was written for professionals, and presented as a university function; its language is suitable to that sober, academic environment and will have little popular appeal. The points are limited by the condition of the presentation. And it is unlikely that the rather fine distinctions between university and vocational training, or the emphasis on the university's function and role, will stimulate revolutionary action.

George A. Silver, M.D., is chief of the Division of Social Medicine at Montefiore Hospital in New York.

**The Crisis in Medical Education*, by Lester J. Evans, M.D., University of Michigan Press.

Briefly, the thesis expressed in Dr. Evans' own words is:

Since medicine has gained phenomenally in recent decades from professional education in the university; and since medicine is now in a period of rapid development; and since much is happening outside the university to enhance the continued growth of medicine, the question is whether medicine any longer needs the university, and if so, why. One answer is most emphatically that it does, but not necessarily for the same purposes as in the past. The alternative is that medical education will lapse into a mid-twentieth-century form of proprietary professional education, the symptoms of which are already in evidence.

One cannot quarrel with this. But is it education of the doctor that fails to produce the socially desirable physician? Will toying with educational methods or location basically affect the product? Is it a failure of the school or of social philosophy?

Sigerist, the well-known medical historian and social scientist, described medicine as a response to, or a reflection of, social need:

The characteristic features of the medical profession are determined to a large extent by the attitude of society towards the human body and by the evaluation of health and disease. The scope of medicine was always the same—to cure disease and eventually to prevent it. Medicine always meant service. Therefore at all times, certain qualities were required of the physician: readiness to help, knowledge concerning the nature of disease, and skill in curing the sick man. However, the medical ideal was a very different one in different periods of history, determined by the structure of society of the time and by its general conception of the world.

One would suppose, if one agrees, that the proper conceptual base for a consideration of "crisis" would therefore be the social attitudes, social values and social philosophy that inform students and teachers.

However, Dr. Evans' essays go on to explore what it is the medical school might add in the way of curriculum development and approach to achieve social ends. For the moment it may be useful to pursue his line. The most interesting chapter is "Yesterday, Today and Tomorrow," which tots up the changes in the past 100 years in the emphasis of medical education and the

trends in social needs that medicine should consider today, but doesn't make any effort to meet. This is a concentration, sincere, intelligent and narrow, on the internal necessities of medical education. But if we recognize that the educational imperative is grounded in a social imperative—what does society expect and need in the way of medical care?—Dr. Evans' earnest assumptions leave us dissatisfied.

I have before me an article from one of the most eminent medical periodicals in the United States, *The New England Journal of Medicine*. It is called "The Training of the Physician" and is written by a well-known physician and emeritus professor, Chester S. Keefer. Dr. Keefer begins as follows:

Medical education in the United States has been undergoing change and reform for the past two centuries. Each reform has had as its objectives improvement and extension—improvement in the methods of teaching and extension of the subjects and of the time required to acquire a basic education. Changes have also been introduced to meet the future needs of specialized training in clinical medicine, and the medical sciences.

The first requisite for any medical educational reform is the faculty, stimulating one another and working together as a unit, with vision, imagination and well defined objectives. The second requisite is a well prepared, interested and inquisitive student body. The third ingredient is an approved curriculum based on the needs of the institution and evolved by its own staff.

How meaningful are such sincere platitudes in the practical terms of what the patient sees, or knows or wants of medical services? Is the profession alone to make decisions about medical care, make determinations as to selection and training? Is the patient then to take what he gets and be pleased with it? One would think the time long past when medical education can be conceived of in a vacuum. Sir Richard Livingston is quoted as having said, "a technician is one who knows everything about his job except its ultimate purpose and social usefulness." Aren't we far beside the point when we are concerned only with the technical education of students to do the medical job better—which job we haven't even defined in social

terms? While Dr. Evans touches only briefly on the selection of students, it seems to me this cannot be so casually dismissed. The emphasis on a scientific knowledge or interest as the basic admission criteria may reflect the necessities of medical education in Keefer's terms, but it does not reflect the necessities of medical education in social terms. There isn't any more sense in this kind of selection than there was in the colonial practice of sending a son to learn to be a doctor because he was too lazy for farming, too ungodly for the ministry and too stupid for the law.

Is it not a matter of deep social concern that the majority of medical students are selected from social classes in the upper-income brackets; that unwillingness or calculated decision on the part of the American Medical Association and the Congress prevents stipends from being made available so as to encourage students from the lower-income groups? Is it not noteworthy, as perhaps either a failure of education or of the profession, that the body representing the organized opinion of the medical profession opposes social-action legislation, and is associated constantly with conservative political activity? Should we be concerned that the organized medical profession opposes a national system of medical care, even for that segment of the population which has the most desperate need and the least resources with which to meet it? Is it distressing that the organized medical profession refuses to support control of cigarette advertising after the evidence for the implication of cigarettes in the causation of cancer of the lung is overwhelming?

While there may be a crisis in medical education, it would seem less critical than the crisis in medical practice or the crisis in understanding between doctors and patients. Such a gulf has arisen between what the doctor does and thinks he ought to do—and therefore expects to be trained for—and what the patient's expectations are, that some bridge will have to be built of understanding and acceptance before any useful educational solutions can be proposed.

More than half a century ago, a temperamental, peppery Kentucky educator named Abraham Flexner struck a blow from which American



medicine has not yet recovered. He generated a series of improvements in outlook, fostering a pre-existing trend toward scientific medical education. He did his job well. Yet because he wasn't a physician but was a superb educator, he described and prescribed improvements in the technique of pedagogy, so to speak. He avoided or disdained consideration of function and social role. What is the doctor for? Is the doctor to make a diagnosis, to prescribe a medicine? Yes, of course. But in the process, he must take into account more than printed lists of normal laboratory standards and symptom formations and X-ray shadows. He must understand the people who are sick, empathize, include their characters and personality in his diagnosis and treatment. Flexner destroyed this conception with great gusto in the holy name of science. With the philanthropic generosity of the Rockefeller Foundation, medical schools have suc-

cessfully crossed the Flexner Rubicon. They train scientists who have little or nothing of social values, insight or concern. Doctors so trained prefer to specialize in increasingly narrower and arcane fields. We are losing family doctors. The doctors who are trained remain in laboratories to study; they play no part in the politics of social betterment. There are proportionately fewer doctors; there is no organization to bring to the people the benefit of the laboratory studies. There is no systematic payment scheme to protect the population from the bankruptcy of the extravagant expense imposed by the new discoveries and inventions. The doctor is powerful enough to avoid most of the consequences of this situation. Illness brings fear and a desperate need for medicine, and the shortage of doctors protects the profession from social sanctions.

The Evans title is misleading: the crisis is in *medicine*, not in

medical education. That is only a symptom, as his text explains clearly enough. At least three interrelated factors contribute to this crisis:

(1) There are too few doctors and they are getting relatively fewer. Part of this shortage arises from the fact that many different kinds of specialties attract graduates in medicine and thereby reduce the effective number of practitioners. Beyond that, we are simply not graduating enough trained doctors.

(2) There is a declining attention to the social values in medical practice.

(3) What medical care there is, is unevenly divided, quantitatively and qualitatively.

An authoritative study by a special commission (the "Bane Report") found only a few years ago that the shortage of doctors was becoming desperately dangerous and recommended at least twenty more medical schools for the United States. Even the American Medical Association, which has long played the tune of increased efficiency and declining prevalence of acute illness, in the hope of forestalling an enlarged labor pool, so to speak, has come to recognize that many more physicians are necessary. And, it may very well be that, until sufficient numbers of physicians are made available, the sellers' market will prevent any appropriate planning or adequate change in provision of more and better medical services for the American people. It should be emphasized, too, that the decline in relative numbers doesn't begin to reflect the real decline in manpower available for the provision of modern medical service. Many medical school graduates never practice. They work in laboratories; they provide teaching services and a variety of industrial and military needs that did not have to be considered in years past.

The dilemma of providing appropriate solutions is compounded by the complexities that have been introduced by the increasing worth of the medical service that can be delivered. Lawrence Henderson said some years ago that 1915 was probably the first year in which the average patient making contact with the average physician stood a better than 50-50 chance of benefiting from the encounter.

Times have changed. The values in medical care, not necessarily life

saving (although this plays a part), but in preventing disability and in easing the added years provided by the improved standard of living and augmented public-health services, have increased the need for coordinated, high-quality family-doctor and specialist services. Without systematic organization to make physicians available in every corner of the United States, so that every citizen can have access to modern medical service, the presence of great medical institutions and of exquisitely trained physicians is a mockery.

We need more medical schools in order to turn out more physicians. We need emphasis on family practice to provide the nucleus around which modern medical care can be delivered. We need more emphasis on organization of practice, with larger clusters of groups of doctors and with the elimination of solo practice that makes it impossible to pull together the threads of good patient care. We need some form of national payment mechanism, either on an insurance basis or from tax funds, to make all of the modern medical care that can be organized this way available to all the people.

This is not a recommendation for "socialized medicine." We have learned over the years that there is no simple solution to the problem of how to get the best modern medical care to people. It will not be obtained simply by passing a law eliminating individual payment. That might serve only to freeze the bad patterns (or lack of pattern) which make it possible for poor medical care or inadequate or insufficient services to be delivered.

We need to tie the whole package together in a new way.

All in all, what we have to deal with is a social problem of distribution of medical services in a systematic way based on modern knowledge. There is as well the professional problem of training physicians to appreciate their social role and the social needs of their patients, inculcating in doctors a willingness to devote themselves to those aspects of patient care that are not purely laboratory- and not purely disease-oriented.

Of course, this really cuts through the value system of the whole American people, not simply that of the physicians. It should be clearly understood that probably the most powerful factor militating against the improvement of medical service, and the development of more adequate services more appropriately paid for, has been the inertia or the actual prejudice of the patient population against such change. One might say that the public gazes at medicine with a kind of helpless fascination, reading book after book and article after article and watching television program after television program about the "problem": fascinated because of the magical cures in the armamentarium available, and helpless because it sees no reliable way of getting at these services.

The obduracy and selfish intransigence of the profession can be overcome, if we can overcome the ignorance (smugness?) of the American people. I suspect that the leadership will have to come from patients and not from doctors. Perhaps only after a catastrophe will

the American people realize what might be done and how. Then they may be willing to undertake heroic measures for the reorganization of medical practice. Perhaps then they will look with new eyes on their neighbor Canada, with a government hospital program ten years old, and stolidly moving into a government medical-care program. How differently are Canadians made? Are their diseases worse? Doctors more docile? I doubt it. They're just more sensible.

The crisis in medical education exists. Lester Evans has delineated it admirably. But the world of doctors requires more than this to come to terms with its times. It requires social planning and organization for medical care and for payment; lifetime educational programs for physicians; experimentation in models of care that will embrace non-M.D.s for some medical jobs; the use of unemployed and technologically unemployed, of school dropouts and minority-group members for specialized health-assistant and administrative jobs, and so on.

It will take careful planning of group-educational activities to persuade the American people that in yielding up their traditional forms of practice they will not have yielded up what they want from that practice; that on the contrary they are more likely to get it. They must learn that developing group practices and developing mass care need not in any way interfere with the personal relationship that they so desperately want and need from medical service—that on the contrary a well-organized method of medical care will *guarantee* them a personal relationship.

AMA: The Restrictive Power Elton Rayack

Without minimizing the large number of quantitative and qualitative factors that determine the level of medical care in America, it is self-evident that a key variable is the number of physicians. No matter how medical care is financed, the availability of doctors places a limitation on the amount and quality of medical services that can be provided.

And whether or not the number of physicians is adequate, however

"adequacy" is defined, depends in great part on the role played by the major professional organization—the American Medical Association. The source of the AMA's power to affect the quantity of medical services supplied has been succinctly described in a classic *Yale Law Journal* article:

A key function of the AMA is its inspection of medical schools and its annual listing of those approved. All states require that an applicant

for medical licensure be a graduate of an acceptable medical school. Standards of acceptability are set by statute, or by formal rule or informal policy of the state medical examining boards. These statutes or rules provide that the board will consider only graduates of schools approved by the AMA and/or the American Association of Medical Colleges, whose lists are identical. Since it is impossible for each state board to make an independent inspection of every medical school

whose graduates apply for licensure, these boards must rely on an outside agency. The AMA fulfills this need and its list thereby acquires the force of law. Through their reliance upon the AMA to inspect the nation's medical schools, the states tacitly confer upon it the power to set the standards for approval. These standards, of course, fix the quality of medical education, but they also indirectly determine the size of classes in each school. Maximum student / faculty or student / cadaver ratios, for example, make expansion costly.

Maintenance of standards is generally accepted as a socially desirable function of professional organizations; this is particularly true with respect to medical care where the quality of services provided may mean the difference between life and death. On the other hand, a professional organization is inevitably concerned with protecting and advancing the economic interests of its members. Since it is inherently difficult to translate "quality" into objective terms, an internal contradiction can arise from the dual role of the professional organization as protector of society's welfare and as defender of its own members' economic interests. The organization can use high "quality" standards as a device for raising the incomes of its members by holding the supply of professional services below the level that might be considered socially desirable.

Organized medicine, i.e., the American Medical Association, has often been accused of restrictionist practices and powerful political lobbying aimed at reducing the supply of physicians' services in order to raise the incomes of doctors. The AMA has vehemently denied such charges and has argued that "even if the Association desired to reduce either the schools or the number of students it could not do so. . . . No private or official body has the power to control the production of physicians in the United States. . . . [The AMA] has always placed its support and assistance at the serv-

Elton Rayack is an associate professor of economics, the College of Business Administration, University of Rhode Island. His present article is based on a fully documented paper which has appeared in two parts in the October, 1964, and January, 1965, issues of Medical Care, a British journal.

ice of any responsible group interested in developing a new medical school."

If the AMA's evaluation of its own activities is correct, then it would be appropriate public policy to encourage it to continue its key role in establishing quality standards and in determining the number of physicians produced by medical schools. However, if the view of its many critics is valid, severe limitations should be placed on the decision-making power of the AMA in the field of medical education. What follows is an analysis of the influence of organized medicine on medical education since the turn of the century.

The Pre-1932 Period

When the AMA began in 1901 to collect and publish medical education data, it initiated a successful thirty-year campaign to raise medical-school standards. In 1904, the AMA created its Council on Medical Education, and the drive to raise standards was accelerated. As a result of the council's inspections, begun in 1906, state boards refused examinations to the graduates of many of the nation's 161 medical schools. Mergers were arranged for some schools; a number of others went out of business.

Shortly thereafter, Abraham Flexner began a comprehensive inspection of medical schools for the Carnegie Foundation with the support of the AMA. His findings were set forth in blistering detail in a monumental study published in 1910, *Medical Education in the United States and Canada*. Of the 155 schools inspected by Flexner,

only twenty-two required one or more years of college work as a prerequisite to admission. Some fifty demanded a high school education or its "equivalent"; the remainder, and by far the greatest number, fell below even that standard, often accepting students with no more than a grammar school education. Many schools were conducted with no more equipment than desks, blackboards and chairs; some without libraries, others without clinical facilities. A number were simply "diploma mills," giving practically no training to their students. The impact of the report was dramatic. "Schools collapsed to the right and left, usually without a murmur."

The pronounced rise in standards resulted in a sharp reduction in the number of medical schools and medical students in the United States. Between 1904 and 1920, the schools dropped from 160 to 88, the students from 28,142 to 14,088, and the graduates from 5,747 to 3,047. During those years fifty-one schools merged, and fifty-one closed down completely. By 1922, the number of graduates had fallen to 2,629, an all-time low for this century and only 46 per cent of the number graduating in 1904. (See Table 1.)

Aside from occasional references in the editorials of *The Journal of the American Medical Association* to the "seriously overcrowded conditions of the profession" and to a supply of physicians in excess of the "normal quantity needed," there is no significant evidence that organized medicine

TABLE 1
MEDICAL SCHOOLS, STUDENTS, AND GRADUATES
SELECTED YEARS, 1904-60

Year	Schools	Students	Graduates
1904	160	28,142	5,747
1910	131	21,526	4,440
1920	88	14,088	3,047
1922	83	16,140	2,629
1929	76	20,878	4,446
1932	76	22,135	4,936
1940	77	21,271	5,097
1950	79	25,103	5,553
1960	85	30,084	7,081

Source: *The Journal of the American Medical Association*, September 3, 1949, pp. 27-93; September 8, 1951, pp. 131-169; and September 13, 1952, p. 109 for data through 1950.

Health, Education and Welfare Trends, 1961 edition; U.S. Department of Health, Education and Welfare, U.S. Government Printing Office, Washington, D.C., for data after 1950.

was pursuing a restrictionist policy for economic gain during the first two decades of this century. The substantial restriction on supply which did occur seems to have been an unintended by-product of a socially justifiable desire to raise the deplorably low standards of medical training.

While the number of schools continued to decline during the 1920s, the number of medical students and graduates increased steadily after 1920, so that by 1929, although still substantially below the 1904 level, the figures closely approximated those for 1910. (See Table 1.) The major factor making the growth possible was the substantial increase in funds medical schools were able to acquire for expansion of facilities.

Throughout the 1920s organized medicine for the most part devoted its efforts to consolidating its gains and did not press for medical education standards higher than had been achieved in the previous decade. While it did not take any aggressive actions aimed at increasing the supply of physicians, neither

did it press for any significant restrictionist measures. On balance, the policies enunciated by the AMA during the 1920s were mildly expansionist.

The Depression Years

By 1932, with the depression deepening, organized medicine had sharply reversed its policies and practices. In place of the mildly expansionist position it had taken in the 1920s, the AMA throughout most of the depressed years of the thirties openly advocated and successfully carried out a policy of restriction.

In 1925, the Association of American Medical Colleges organized the Commission on Medical Education to make a study of the principles involved in medical education and licensure. The investigations of the commission were in great part financed by the American Medical Association. The commission's *Final Report*, released in 1932, stated: "It is clear that in the immediate past there has been a larger production [of physicians] than necessary and that at the present time we have an oversupply . . . of at least 25,000 physicians in this country." The report argued that "An oversupply is likely to introduce excessive economic competition, the performance of unnecessary services, an elevated total cost of medical care, and conditions in the profession which will not encourage students of superior ability and character to enter the profession." The concern of the commission over "excessive economic competition" was undoubtedly a product of sharply falling medical incomes. Between 1929 and 1932 the incomes of physicians dropped almost 40 per cent.

In a not too veiled recommendation for a restrictionist policy, the report concluded that "those responsible for medical education and for the licensure of physicians, particularly for graduates from foreign medical schools, should have the situation clearly before them."

The AMA's house organ, *The Journal of the American Medical Association*, took off from the commission's report and in editorials and articles in 1932 and 1933 hammered away at the need for what it called "professional birth control." A few quotations from various issues of the *AMA Journal*

make evident the basis of organized medicine's concern:

[There is] a growing tendency for prospective medical school students in excess of the numbers which our own schools can accommodate to seek their professional training in Europe and Canada and return to the United States and practice. . . .

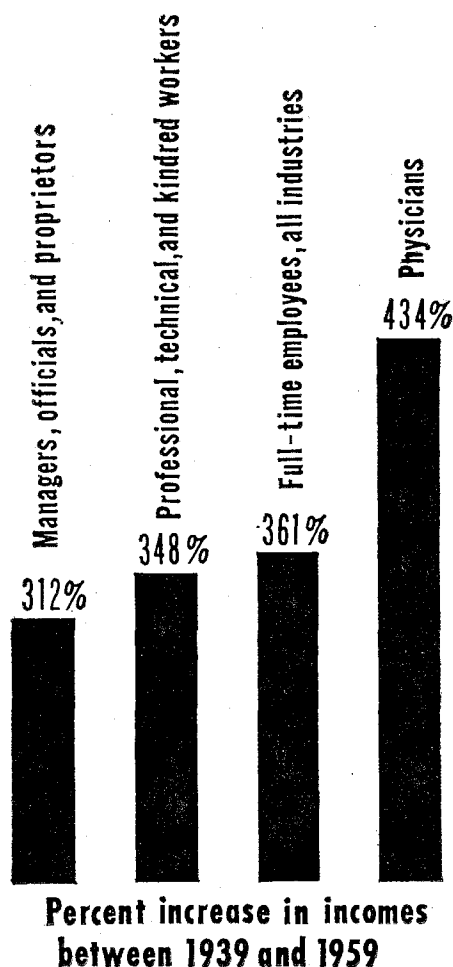
The United States already has more doctors in proportion to its population than any other country in the world. . . . If this ratio is still further increased it is evident that an oversupply of doctors threatens with an inevitable lowering of the standards of the profession. . . .

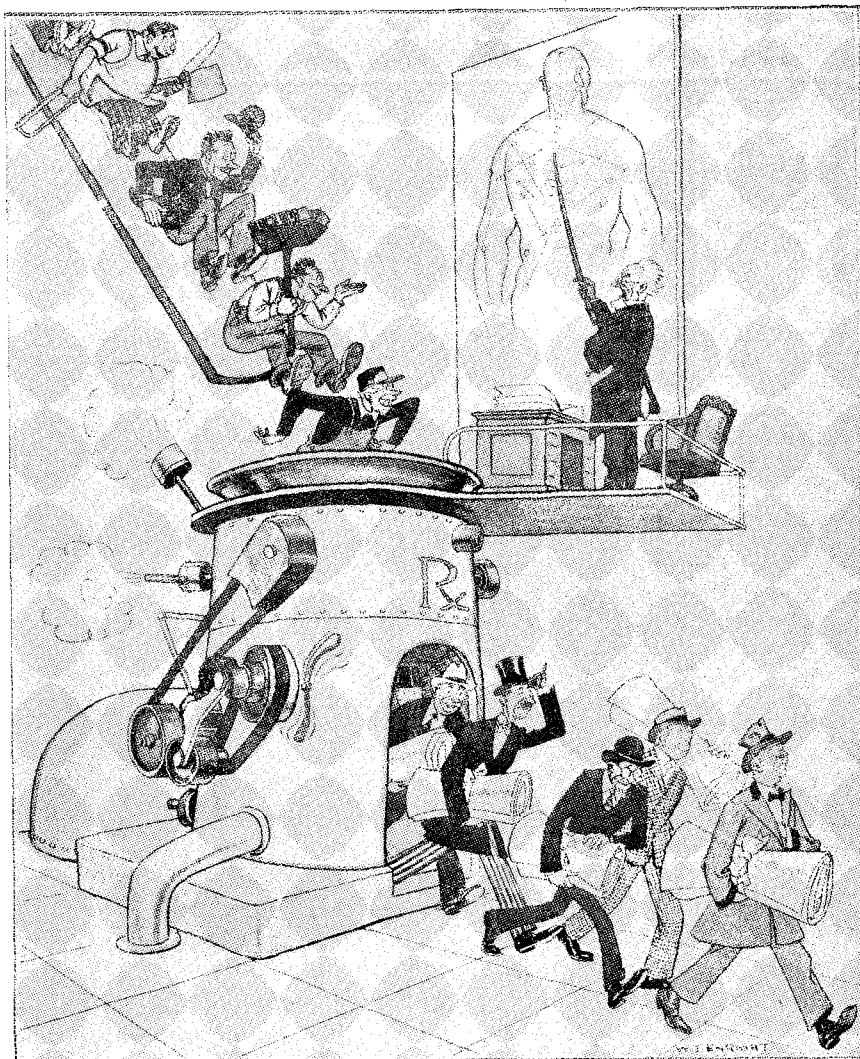
There is an overproduction of medical men [and medical colleges should be required] to reduce the number of graduates 25 per cent each year until a ratio of one doctor to 2,000 of population is reached. . . .

Unless the states promptly initiate measures to restrict the number of those licensed to practice medicine, a great surplus of unemployed doctors will become apparent.

In his presidential address before the AMA convention, in mid-1933, Dr. Dean D. Lewis asserted: "There apparently is an overproduction of doctors. How such an overproduction can be controlled is a problem for the Council on Medical Education and Hospitals." A year later there was no question in the mind of the new president of the AMA, Dr. Walter L. Bierring, concerning both the overproduction of doctors and what to do about it:

One is forced to the conviction that more doctors are being turned out than society needs and can comfortably reward. . . . With the pendulum swinging toward a balanced population, it will be clearly evident that the time is coming, and not far distant, when the principal function of medical service can be effectively furnished by half the number of physicians actually practicing in the United States. It is only natural to place the responsibility with the medical schools, in that they hold in their hands the power to control the supply of physicians for the future, but the time has arrived for the American Medical Association to take the initiative and point the way. During the coming year the Association, through the Council on Medical Education and Hospitals, will institute a resurvey of the medical schools of this country. Whether the problems of this new day in medicine will be met by a limita-





Diploma Mill: 1924

Ladies Home Journal

tion in the number of existing institutions or the number of students cannot be foretold, but it will require real courage and tenacity to bend the educational processes to the urgent social and economic needs of the changing order. A fine piece of educational work could well be done if we were to use only half of the seventy-odd medical schools in the United States.

He also pointed to the "invariable practice" in the trades and handicrafts, "sanctioned by years of tradition," to "limit the entry," and asserted that "similar practices will have to be recognized in the medical profession."

The institution assigned the role of carrying out organized medicine's deliberate effort to limit the supply of physicians during the 1930s was the AMA's Council on Medical Education and Hospitals. At its meeting in June, 1933, the council adopted a resolution asking the Association of American

Medical Colleges to use its influence to reduce the number of graduates. In a speech before the association's annual meeting in October, 1934, the chairman of the council stated that "there is a definite tendency to limit the number of students of medicine in the United States" and that "there is a question whether so many medical schools are required."

In August, 1935, the Council disclosed that it had "issued a general warning against the admission of larger classes than can properly be accommodated or than can reasonably be expected to satisfy approved scholastic standards." That the council's urgings were effective is indicated in its report that "seven schools have definitely stated that their enrollment will be decreased and others have indicated adherence to the Council's principles."

The AMA, however, was still not satisfied. In a JAMA editorial on the above report it argued that "We

have returned to the place where we were when the Council was created. . . . [There has been] a failure to limit admission to carefully selected and well-qualified students. Unless this tendency is overcome there must result, inevitably, a lowering of the standards of medical education and practice. The tendency has been receiving the attention of the Council."

The mechanism for exerting pressure on the medical colleges was the survey conducted by the American Medical Association's Council on Medical Education in cooperation with the Federation of State Medical Boards and the Association of American Medical Colleges. During 1934 to 1936, the council visited and evaluated eighty-nine schools in the United States and Canada. In reporting on its survey to the Annual Congress on Medical Education in 1936, the council was able to state that "Most of the schools . . . which . . . allowed themselves to yield to the demands of this increasing number of applicants and to take in larger numbers of students than they have been able to care for properly . . . have expressed their readiness to cooperate with us by reducing the size of their student body." In 1937, the chairman of the council reported that "a reduction in the quota of students received for admission is now being made by a number of our medical schools."

The intention of organized medicine to use the school survey to restrict the supply of physicians during the 1930s was baldly set forth in the following statement by the Federation of State Medical Boards:

While the main purpose [of the survey] is the improvement of existing methods of training for the future practice of medicine, other beneficial results are becoming evident. Careful estimates made during the past year indicate that 500 fewer students registered in acceptable medical schools in 1935, compared with the previous year. If this condition should prevail for twenty years, it would mean approximately 10,000 fewer graduates entering the practice of medicine. The implication of this on the welfare of the future practitioner is evident. . . .

That the pressure exerted on the medical schools by the AMA to cut back enrollment had a substantial

TABLE 2

APPLICANTS TO MEDICAL SCHOOLS, ACCEPTANCES, AND
PER CENT ACCEPTED, 1932-52

Academic Year	Applicants	Acceptances	Per Cent Accepted
1932-33	12,280	7,357	60.0
1933-34	12,128	7,578	62.5
1934-35	12,779	7,419	57.9
1935-36	12,740	6,900	54.1
1936-37	12,192	6,465	52.8
1937-38	12,207	6,410	52.5
1938-39	12,131	6,223	51.4
1939-40	11,800	6,211	52.6
1940-41	11,854	6,328	53.5
1941-42	11,940	6,822	57.5
1942-43	14,043	6,835	48.9
1943-47		Not Available	
1947-48	18,829	6,512	34.2
1948-49	24,242	6,973	28.8
1949-50	24,434	7,150	29.3
1950-51	22,280	7,254	32.6
1951-52	19,920	7,663	38.5

Source: *The Journal of Medical Education*, March, 1960, pp. 224-225.

impact is clearly shown in Table 2. Despite the fact that there was almost no change in the number of applicants between the academic years 1933-34 and 1938-39, the number of acceptances fell 1,355, a decline of 17.9 per cent, and the ratio of applicants to acceptances fell 17.8 per cent. It is particularly significant that fully 74 per cent of the decline in the number of acceptances occurred within the two years after the AMA's Council on Medical Education warned the medical schools in 1935 against the admission of larger classes. The success of organized medicine's restrictionist activities during the 1930s contributed to the shortage of physicians which persisted through the 1940s and 1950s.

The War and Postwar Years

With the total mobilization of resources during World War II and the sharply increased demand for doctors from the armed forces, organized medicine's effort to hold down enrollment in medical schools was suspended. In anticipation of wartime needs, accelerated programs were adopted by medical schools in 1941 without AMA opposition.

In the postwar years the demand for medical services continued to grow and there was a pronounced rise in the number of applicants to medical schools. Although pressure for medical education rose tremendously, the inadequacy of existing facilities set a limit to the students who could be enrolled. Thus, al-

though the annual number of applicants for the years 1947 through 1950 was about double the prewar rate, the increase in acceptances was relatively small. While in the prewar years more than 50 per cent of the applicants were accepted, after the war acceptances dropped to about 30 per cent. (See Table 2.)

In the face of the rising demand for medical education and the resultant strains imposed on medical schools, the AMA again turned toward restriction. However, instead of exerting direct pressure on medical schools to curtail enrollment (this was no longer necessary, since a ceiling on admissions was automatically established by the limited facilities), the AMA now vigorously opposed much-needed federal aid to medical education.

The 1946-50 Period. Organized medicine's opposition to federal aid began to develop as early as mid-1946 when the AMA's Council on Medical Education and Hospitals asserted that "an overall increased present or postwar need for additional physicians occasioned by the war can be provided by existing medical schools."

When the U.S. Public Health Service early in 1948 forecast that a serious shortage of physicians would occur by 1960, the council declared that it was "concerned that these forecasts would result in pressure being brought to bear on the medical schools of the country to accept more students than they can properly train"; and that "alarm

over the supply of physicians is unwarranted." The council was "strongly of the opinion that before resort is made to federal subsidy, an intensive and concerted effort be made to secure the funds required by the medical schools from private sources." To secure such support it recommended the establishment of a National Foundation for Medical Education.

In 1949, several bills providing for various types of aid to medical education were presented in both houses of Congress. Most of these included some sort of incentive plan for stimulating increased enrollment in medical schools, construction grants for the establishment of new schools and for the expansion of existing facilities, and federal subsidies for scholarship assistance.

During Senate hearings, the representatives of the AMA's Council on Medical Education conceded that "there is no question" about the need "for assistance to medical schools," but stressed their fear of the "unknown implications and consequences of federal aid." The tenor of their testimony clearly reflected a negative attitude as they emphasized the points that "the insufficiency of our present production of physicians has been exaggerated" and that the "problem of supply of physicians is more specifically a problem of distribution, rather than of overall numbers."

In their comments on the specific provisions of the bills, the first and strongest objections raised by the AMA were to those sections designed to stimulate enrollment. They argued that the bills "place disproportionate emphasis on assisting the schools to increase their enrollments and insufficient emphasis on aiding the schools to strengthen and improve their present programs," and that "the wide spread between the \$300 to be paid for each student up to the average past enrollment and the \$1,700 to be paid for each additional student [as proposed in the legislation] . . . may . . . be questioned on the grounds that it offers a financial premium which might induce certain schools to enroll more students than they can properly accommodate." They also objected to the fact that "new schools would be greatly favored over existing medical schools since

new schools would receive \$850 for every student they enrolled."

If the AMA had really been concerned about quality, it had (and still has) the power to maintain standards through the periodic examinations by its Council on Medical Education and Hospitals. The AMA held that "the formulas that are adopted should reflect the fact that federal aid to medical education will be most effective . . . if such support is directed to stabilizing and improving our present programs of medical education." Clearly, the objection was not to federal aid per se, but to federal aid that would lead to increased enrollment in medical schools.

Two other points in the AMA testimony of that time indicated its desire to hold back the growth of medical education. One was its recommendation that the ceiling on federal aid for costs of instruction be placed at 30 per cent of the instructional budget rather than at 50 per cent as in the bills under consideration. The other was its contention that an accurate estimate of the financial needs for the schools could be computed only after each school had made a detailed study of its needs and that the AMA, together with the Association of American Medical Colleges, had initiated such a study which would extend over the next three years. Since the AAMC had already stated before the same Congressional committee that federal aid was necessary, the AMA emphasis on the need for a three-year study seems a clear attempt to postpone action. Furthermore, the AMA Council on Medical Education had a year earlier reported the following on the basis of its own survey:

The medical schools . . . are almost unanimous in declaring that if they are to continue to meet problems of inflation successfully and if they are to undertake new developments important to their fundamental programs of undergraduate medical education, they will require additional operating funds in addition to those currently available. About four-fifths of the schools were able to furnish estimates of their needs. On the basis of the figures submitted, it can be estimated that the additional funds needed by all the medical schools amount to about \$15,000,000 annually. . . .

The medical schools were also asked to estimate the additional

funds that they need for capital developments. Five schools indicated that they did not need additional funds. Seventeen schools were unable to furnish estimates. Fifty-five schools supplied estimates which totaled \$197,357,960.

In its own *History of the American Medical Association* the AMA offered the following description of the postwar financial position of American medical schools: "With the termination of the war and the discontinuing of acceleration and the well-paying military programs, there was a sharp reduction in revenues from students. In a goodly number of schools this has precipitated a serious financial crisis. Financial support from other sources must be forthcoming in greatly increased amounts if medical schools are to continue at their former high level of performance in the training of doctors."

But when AMA officials appeared before Congressional committees, their testimony virtually ignored the evidence in their own publications. Dr. Louis Bauer, a member of the AMA's board of trustees, when asked by Senator Murray whether he thought the problem of medical education was serious, replied: "No sir, I think it is being taken care of. . . . The problem of producing more doctors . . . is being taken care of satisfactorily because we are turning out more now than we ever have, with prospects of still more." Just six months after Dr. Bauer's Congressional testimony, the council presented to the AMA's House of Delegates a report which contained the following: "During recent years the Council has reported frequently to the House of Delegates that a major problem in medical education today is the need for more adequate financial support of the medical schools." Thus the AMA's own studies contradicted its representative's Congressional testimony!

As a result of AMA pressure on the professional staff of the Senate Subcommittee on Health, major changes were made in the proposed legislation. The important modifications were as follows:

(1) Payments to medical schools were changed from \$300 for each student enrolled up to a school's average past enrollment, and \$1,700 for each student enrolled in excess

of average past enrollment to \$500 and \$1,000 respectively. A limitation of 30 per cent of the average past enrollment was placed on the number of students for which the higher rate would be paid.

(2) Total permissible federal subsidies to any school were cut from 50 per cent of the school's budget to 30 per cent.

(3) The scholarship provision was rewritten so that no scholarships would be provided as long as the medical schools were able to fill their enrollments with students who did not need such aid.

After the diluted bill was unanimously passed by the Senate, the AMA's Council on Medical Education commented that while it was "not entirely satisfied with the bill, it does incorporate several modifications suggested by the Council's representatives and it is a distinct improvement over any other bill for federal aid to medical education that has been introduced." The council's report to the AMA's House of Delegates in November, 1949, stated that "the chief objection to the bill in its present form is that it provides that osteopathic schools will receive the same aid as medical schools." It is important to note that the council at that time set forth no other objection. Furthermore, on the issue of the continued freedom and independence of medical schools, it found that "the legislation which has been passed by the Senate contains safeguards that should protect medical schools from unwarranted interference in their affairs by the federal government."

However, when the revised bill went to the House and passage seemed assured, the AMA suddenly shifted ground and came out strongly against enactment. The Council on Medical Education now reported to the board of trustees that, despite the concessions which represented "improvements," the bill contained "several provisions which were objectionable to varying degrees." The council cited three provisions which it now looked upon with particular disfavor. First, it objected that the proposal to pay new medical schools \$1,000 per student for all students "unduly and unfairly favors new schools over established schools." The AMA recommended a limitation on such payments to 30 per cent of the enrollment. A second objection was

to the provision of \$5 million annually for construction of new schools in the health professions and for expansion of existing facilities. The council held that "no grants for construction should be made until the needs of all medical schools had been surveyed and a balanced, long-range program developed." Finally, the council opposed giving a proposed governmental agency the "authority to investigate the medical schools and to determine their capacity to maintain and extend student enrollments."

The board of trustees concluded that "it must urge opposition to the enactment of the bill" basically on the ground that it was "potentially dangerous to the continued academic freedom of the medical schools. . . . No program should be embarked on until protection of this freedom is absolutely guaranteed."

The House companion bill to the Senate measure was favorably acted upon in the Committee on Interstate and Foreign Commerce and referred to the Rules Committee with a recommendation for passage. However, the Rules Committee failed to grant a rule and the bill perished there as the session ended. In the next session, the House bill was recalled by the Commerce committee from the Rules Committee, completely rewritten and then tabled by a one-vote margin. Two more medical school aid bills were introduced in the House during that session and tabled in committee, one of them also by a one-vote margin.

The tactics and statements of the AMA leadership with respect to the bill passed by the Senate, and the companion bills introduced and killed in the House, make it clear that their basic goal was to restrict the expansion of medical school facilities and thereby hold down the supply of physicians. In both 1949 and 1950, the years during which those bills were under consideration, the AMA was the heaviest spender among the Washington lobbies. Thus, despite the fact that literally thousands of potential students were being barred from medical training because the schools had reached the limits of their capacity, despite the fact that the legislation had been endorsed by the deans of all ten accredited schools of public health and by

about 75 per cent of the deans of medical schools, despite the fact that the AMA in its own *Journal* had frequently reported on the very weak financial position of medical education, organized medicine was able to exert enough pressure on Congressional committees to block federal aid to medical education.

The 1951-58 Period. Because the pressure for federal aid continued, organized medicine in 1951 felt compelled to modify its rigid stance of outright opposition. The AMA realized, in the words of its president, that "opposition . . . is not enough. We must have a constructive program for raising money for medical education." The new approach called for a two-part plan: (1) federal grants to individual medical schools on a matching basis for construction purposes only, with no part of the funds to be used for operational expenses; (2) an attempt to meet operational expenses from private sources.

Although accepting the principle of one-time construction grants, the AMA still stood "unalterably opposed" to federal subsidies for instructional costs until all private and state means of support had been exhausted. The new approach was thus another delaying action, since a significant increase in enrollment could not occur without substantial additions to the operating revenues of medical schools. As Howard Rusk reported in *The New York Times*: "The basic barrier to increasing the national supply of physicians is the limited capacity of medical schools. . . . Numerous studies conducted over the last few years have shown that medical schools needed from \$10,000,000 to \$40,000,000 in increased operating expenses each year and a minimum of several hundred million dollars for new construction and capital expansion."

In S.1323 and its companion bill H.R.4743, the AMA in 1955 at last found a construction grant proposal which it could support. However, endorsement by the AMA was far from vigorous. Its representatives testified in Washington that "the number of physicians in this country by any reasonable yardstick is adequate and the number of physicians now being produced by the medical schools we have is increasing in number and maintaining a high quality, increasing in number

at a faster rate than our population is increasing." Although they conceded that "there may be some maladjustment of the distribution of doctors," the tenor of their testimony certainly was not calculated to stimulate Congressional support!

Furthermore, the association suggested one important amendment—the deletion of an incentive section providing that the federal government would bear a higher share of the cost of construction if a school gave satisfactory assurances of a 5 per cent increase in enrollment. The AMA argued that the incentive provision establishes a "dangerous principle" which might induce medical schools "to increase their enrollment more rapidly than is justified by their facilities, personnel, and teaching material." Thus the AMA was unwilling to accept an incentive for even a modest increase in enrollment.

The cautious AMA approach to the above legislation contrasted sharply with the "enthusiastic endorsement" voiced by the Association of American Medical Colleges. Of eighty-two medical schools responding to a poll, the AAMC reported that "96 per cent favor the bill, an amazingly high degree of unanimity among academic folk." The medical colleges' association held that the "incentive . . . will be a wholesome stimulus to the medical schools to expand as rapidly as possible and that there are accrediting agencies which will guard against overexpansion at the expense of quality."

The Eisenhower administration opposed aid to medical education at that time on the grounds, characteristically, that such legislation should be postponed until it could be considered as part of a "broader inquiry into the costs of higher education." Opposed by the administration and very feebly supported by the AMA, the bills failed to pass the Senate and were not considered by the House. Congressional hearings were held again in 1958 and the AMA testimony was almost a verbatim repetition of its 1955 statement.

Throughout the 1951-58 period, the AMA held to its position that there was no danger of a physician shortage. In 1951, the director of its Bureau of Medical Economic Research went even further, stating that the bureau's analysis "points

toward a surplus or a potential surplus of physicians rather than a deficit." Four presidents of the AMA in 1952, 1953, 1954 and 1956, and numerous JAMA editorials, asserted that there was no shortage of physicians and that the problem was merely one of regional distribution. When reports by various government agencies used physician-population ratios to indicate a current or prospective shortage, the AMA argued, as recently as 1957, that the use of such ratios is "replete with fallacies" and not a true measure of the demand or supply of physicians. Even the problem of regional distribution was ultimately reduced to insignificance when the Medical Economics Bureau in 1954 concluded that the addition of a mere 361 physicians would eliminate the maldistribution. The editorial comment of the JAMA on this finding is worth quoting at length, not only for what it reveals about AMA thinking, but because it dramatizes the sharp reversal of attitude organized medicine was to take in 1959. The editorial stated:

This report effectively sets at rest so many rumors regarding the distribution of physicians in the United States and throws so much light on the so-called national shortage of physicians that it may have an impact on its field comparable to that of the Flexner investigation of medical education in 1910. . . . This figure of 361 is a strange contrast with the series of predictions emanating from Federal agencies during the past half-dozen years placing the so-called national doctor shortage at 22,000 to 49,000. This forthcoming report should mark the beginning of the end of irresponsible and fantastic propaganda regarding the need for sweeping measures to greatly expand the number of physicians. The maintenance of high quality in the training of future physicians is, of course, another and different question.

1959 to the Present. In the brief period between June, 1958, and May, 1960, three major comprehensive studies of the needs of medical education in the United States were made by groups of government consultants drawn from education, medicine, industry and public service: the Baynes-Jones Report in 1958, the Bane Report in 1959 and the Jones Report in 1960. They agreed that *merely to maintain* our present physician-population ratio it would be necessary to



Valtman, Hartford Times
"God Forgive—I Have an Urge To Kill"

build within the next decade from fourteen to twenty new medical schools as well as expand existing facilities—an increase in ten years that would be greater than the growth over the past forty years! The reports also recommended substantial federal aid for both construction and operating expenses, as well as for scholarships and loans. These proposals were set forth as *minimum* estimates of need.

On the basis of the studies, legislation to assist medical education was introduced in Congress in 1960 and 1962, and strongly endorsed by President Kennedy when he called on Congress to provide funds which would assist in the construction of twenty new medical schools by 1970 and make substantial scholarship assistance available for medical students. The overwhelming sense of urgency in the reports finally forced the AMA to a gradual but full retreat from its oft-repeated assertion that there was no current or prospective danger of a physician shortage.

After the first report was released in 1958, the AMA's Council on Medical Education and Hospitals made its initial, albeit cautious, formal recognition of the need for increasing the number of physicians: "The Council . . . recognizes the physician-population ratios, on which most current projections of medical personnel have been made, have remained relatively constant for a number of years. It is difficult, however, in the rapidly changing modern scene, to determine whether this relative ratio of physicians per unit of population might be reduced or should be augmented to meet the medical care, teaching and research challenges of the future. On the other hand, the increasing pop-

ulation, together with the various other facets of the shifting pattern, obviously necessitates consideration on the part of existing medical schools as to the possible augmentation of the number of students admitted as well as the development of new facilities."

A year later, after the second report was released, the AMA's council pronounced: "It appears that the best available knowledge for projecting future medical manpower is on the basis of the existing physician-population ratio. . . . Several recent studies . . . indicate clearly that there will be required a significant increase in the number of physicians graduated to maintain the present ratio. . . . The fundamental issue does not involve the question of which of the various studies have resulted in the most accurate estimate of the need for increased numbers of medical school graduates. *The basic and urgent concern is that all estimates indicate a need for expansion of educational facilities in medicine in a brief period which far exceeds any expansion of such facilities that has occurred in a similar period during modern times.*" (Italics in original.)

Only two years earlier the AMA had pronounced forecasts based on physician-population ratios "fallacious," and had dismissed those who forecast doctor shortages as "alarmists."

When the third report was issued in 1960, the AMA referred to the council's statement of the previous year, and commented that "during the intervening year, little has occurred to alleviate this concern." The AMA's "concern," however, did not lead it to take a more vigorous stand for federal aid. In 1960 and 1962, medical education bills very similar to those already discussed were under consideration by Congressional committees. Included in the legislation were proposals for substantial federal grants for construction of facilities and for scholarships and loan assistance for medical students.

At Congressional hearings held in 1960, the AMA, while stating that "there is sufficient need for . . . construction . . . to justify a one-time expenditure of Federal funds on a matching basis," again called federal aid "a dangerous device because of the degree of control and regulation which must ac-

company Federal funds." Although it announced its support of the construction aid bill, it asked once more for elimination of the incentive provision. With respect to scholarships and loans to students, the AMA said that it could not at that time make any comment, as those subjects "were presently under consideration by committees of the association." At the 1962 hearings, the association's position remained unchanged except for a concession implicit in the fact that it did not mention the incentive aspects of the proposed construction program.

When questioned again as to the AMA's attitude on federal assistance for scholarships, its representative stated: "We have taken no position on the scholarships. [The Council on Medical Education and Hospitals] is making a study on scholarships." Thus, after more than fifteen years of public discussion, thousands of pages of Congressional hearings, a number of comprehensive reports by private groups and government agencies, and annual reports on medical education by the AMA's own Council on Medical Education, organized medicine could not lend its support to federal scholarship assistance because it was still "studying" the problem!

The sense of urgency arising from the Congressional testimony of the Association of American Medical Colleges is in marked contrast to the relatively placid attitude of the AMA. The AAMC representatives argued that "we must in a decade or less increase by 50 per cent facilities that required nearly 200 years of private and local effort to establish." They told Congress that "all the existing 86 medical schools . . . agreed . . . that an expansion of this magnitude can be accomplished in the time required only if Federal funds on a matching basis are available." They also stated that to meet the desired goals "more adequate scholarship funds will be needed than can be raised from local or private sources," and that "Federal participation in the effort to provide this financial assistance is needed and well justified in the national interest." Furthermore, in an obvious reference to the AMA, the AAMC representatives informed Congress that "the Association of American Medical Colleges does not

fear that this legislation will lead to Federal interference. . . . For more than two decades our member institutions have had extensive experience with large, diverse, and growing Federal programs for the support of research and research training and have found them singularly free of such interference."

A number of medical school aid bills were again introduced in Congress in 1963; as before, they called for construction grants and loans and scholarship assistance for medical students. Although the AMA had finally admitted the critical need for federal aid for construction, the Congressional testimony of its representatives and the efforts of its lobbyists indicate that this concession was little more than a minimum necessary concession in a highly successful seventeen-year delaying action against efforts to increase the supply of physicians. The validity of this statement is borne out by the AMA stand on federal loans for medical students.

When asked by Congressman Brozman at one of the hearings, "Do you have any opinion as to whether or not a need exists for Federal moneys as regards loans to students?" Dr. Dorman, the AMA representative, replied: "On this specific item we do not have any official position. There is need for loans to students. The question comes up whether this should be from Federal sources, and on this we have no specific position either for or against. We do not oppose it." When questioned as to whether he believed that the AMA privately sponsored loan program was adequate, Dr. Dorman admitted that it was not, adding: "We did not say it was adequate. . . . It does not carry the full load, and I do not believe it ever could."

Despite this testimony, on the day before the bill came up to a vote, the AMA sent letters to every member of the House declaring its opposition to the loans.

The supporters of federal aid for medical schools finally won their first legislative victory in their seventeen-year struggle with organized medicine when, late in 1963, Congress passed The Health Professions Educational Assistance Act. The Act made available construction grants and loans for students, but contained no provision for much-needed aid to the schools' operating expenses.

The size to which the construction gap had grown may be seen in the fact that under the Act ninety medical and dental schools have requested \$247 million in federal aid for construction. Only \$100 million has been authorized by Congress for 1965, and the full authorization for 1966 will provide only \$75 million more. To meet the current needs, President Johnson has asked Congress to appropriate the full amount authorized under the Health Professions Act. Furthermore, the President has recommended legislation for federal aid to meet basic operating expenses and for scholarships.

Although the AMA based its opposition to federal aid for medical education, and in particular to federal aid for operating expenses, primarily on the "threat" that such assistance posed to the "freedom" of medical schools, no evidence could be found of organized medicine's opposition to similar multi-million-dollar aid programs for medical research. Neither has the AMA expressed any fear of federal aid for hospital construction; on the contrary, when the Hill-Burton bill providing federal grants for hospital construction was being considered by Congress in 1945 and 1946, the AMA supported the proposals with great vigor. The bill, certainly one of the most important health acts ever adopted in the United States, was passed in 1946. By 1960, 3,232 hospital projects had been completed under the Hill-Burton program, adding approximately 143,000 beds at a cost of \$2.7 billion.

The explanation for this manifestly ambivalent attitude toward federal aid seems clear: aid for research and hospital construction tends to increase the *demand* for medical practitioners, whereas aid for education tends to increase the *supply*—the former exerts an upward pressure on medical incomes whereas the latter exerts a downward pressure!

The activities of organized medicine during the past three decades raise a basic policy issue: Should society continue to sanction the substantial restrictionist power exercised by the American Medical Association in connection with its legitimate concern for quality in medical education? The evidence strongly suggests that it would be socially desirable to curb the power

of the AMA. How can this be done?

One of the most radical solutions is the completely laissez-faire proposal recently put forward by Professor Milton Friedman of the University of Chicago that "licensure should be eliminated as a requirement for the practice of medicine." His argument may be summarized as follows: Licensure is the "key to the control" that the AMA exercises over the number of physicians. The AMA, "perhaps the strongest trade union in the United States," limits the number of people who can practice medicine. Its "essential control is at the stage of admission to medical school." Medical schools are approved by the AMA's Council on Medical Education and Hospitals. To stay on the approved list, a school must meet the standards set by the council. The council's approval is crucial for the continued existence of a medical school since "in almost every state in the United States, a person must be licensed to practice medi-

cine, and to get the license, he must be a graduate of an approved school. In almost every state, the list of approved schools is identical with the list of schools approved by the Council. . . . That is why the licensure provision is the key to the effective control of admission." By directly exerting pressure on medical schools to restrict admissions, as it did in the 1930s, or indirectly, by raising "quality" standards, the AMA's Council on Medical Education and Hospitals has reduced the supply of physicians.

In place of licensure, Professor Friedman would substitute the freedom to practice medicine "without restriction except for the legal and financial responsibility for any harm done to others through fraud and negligence." The major reservation I have concerning Professor Friedman's proposal, and it is a crucial reservation, is my doubt that a completely free market can produce medical services of adequate quality. The need for quality is the

basic reason for society's willingness to grant organized medicine substantial power to set standards for medical education.

The two extreme and diametrically opposed approaches of placing almost complete power in the hands of organized medicine, and of reliance upon a free market, suggest a third alternative: greater lay control over the licensure of physicians and the admissions policies of medical schools, with organized medicine playing an essentially advisory role. Such an arrangement would make it possible to give due consideration to the need for quality, and at the same time would provide a necessary check on the use of quality standards as a device for unduly restricting the quantity of medical services supplied. While such an approach might not completely eliminate the inherent contradictions in the concept of professionalism, it would lessen considerably their socially undesirable effects.

The Impact of Medicare Stanley Meisler

Washington, D.C.
Medicare will be "the most sweeping new departure in American social legislation since Roosevelt's Social Security Act thirty years ago." That description, culled from one of the many news accounts of House passage of the bill, already has deadened into a cliché. All analysts have accepted the fact of medicare's great impact, but very few have bothered to delve into the details of that impact. How will America and medicine change after medicare?

Only a fool would try to predict this with certainty. A bill, especially one 296 pages long, has byways and tremors and lurking commas that can twist society in a manner no one anticipates. Yet some trends can be spotted ahead of time. Medicare has the potential to confirm doctors' fears that federal pressures will change the way they practice medicine. It also has the potential to stuff a financial bonanza into the pockets of America's fat-cat doctors.

The bill, which is sure to become law some time this summer, states that nothing in it "shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." Yet the bill also exacts standards of institutions that take part in the program. While these standards are not, at least initially, to be federally administered, they do amount to a form of federal influence and pressure for improvements that medicine has not accomplished itself.

Every hospital under medicare would have to follow the lead of the most progressive hospitals, and appoint a committee to review cases periodically, to see that no doctor was keeping his patient in the hospital too long. This is a standard not now required for accreditation by the American Hospital Association and one that most doctors resent. These utilization review committees—made up of hospital physicians, nurses and social workers—would be set up to insure efficient use of the hospital

and to guard against the tendency of some patients—with their doctor's approval—to stay in a hospital for as long as their insurance will pay for the bed. The bill does not detail the criteria a utilization review committee must use, but the mere inclusion of the provision creates a mechanism for checking on the judgment of doctors.

Another provision of the bill allows a doctor to transfer a patient no longer in need of intense hospital care to a nursing home for twenty to eighty days of free care, and this may prove a boon to the overtaxed hospitals. Some hospital people feel the bill errs by requiring the doctor to put the patient in a hospital first; they believe the doctor should have the right to send the patient to the nursing home initially if he feels that that is the best way of handling the illness. There is some expectation that doctors will solve the problem by putting a patient in a hospital for the allowed minimum of three days and then transferring him to the nursing home. This would be a clear waste of money

Stanley Meisler is a frequent Nation contributor.

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— since hospitalization costs are four times as high as those of nursing homes.

Still a third provision in the bill allows federal pressure on medical practices. Ironically, this was put into the bill by Rep. Wilbur Mills (D., Ark.), chairman of the House Ways and Means Committee, at the request of the AMA, which has screamed for years about the danger of federal interference. The provision prohibits any allocation of the hospitalization benefits as payment for the services of the anesthesiologist, pathologist, radiologist or other medical specialist attached to the hospital. Each of these doctors would have to bill the patient separately.

This prohibition—which may be deleted in the Senate—would represent a victory for the AMA in one of its long-time feuds with the American Hospital Association. The AHA wants hospitals to serve as comprehensive medical centers ready to treat patients in an organized, economical, efficient way. The AMA, on the other hand, wants hospitals to serve as workshops in which individual entrepreneur physicians ply their trade. In recent years, the trend has favored the AHA, and most radiologists, pathologists and other specialists have accepted an arrangement that put them under hospital administra-

tion and provided them with a percentage of the charges.

Medicare—as passed by the House—would discourage hospitals from making arrangements that would draw these specialists into a comprehensive medical center. “In the long run,” says Eugene D. Morris, administrator of Edward Hospital of Naperville, Ill., “it would reduce the hospital to little more than a nursing home.” Sen. Paul Douglas (D., Ill.) recently gave Congress an example of what might happen if a pathologist was a private entrepreneur and not under the administration of the hospital:

“At the present time, the hospital pathologist can go into a medical staff meeting and tell Dr. Feesplitter that 25 per cent of the tissue he removed was normal. . . . The pathologist has this freedom to criticize because he is paid by the hospital, and his responsibility is to the hospital. This freedom of action would be seriously impaired by the present House provision. The pathologist would be dependent upon referrals from physicians such as Dr. Feesplitter for his income.”

The provision also would create an administrative quagmire as every specialist in the hospital presented his separate bill to the patient, and as the hospital figured out the percentage of laboratory

charges, for example, to be billed by the pathologist. “I have seen an estimate made by the director of a major hospital in the East,” says Sen. Frank Moss (D., Utah), “that radiologists on that hospital staff would have to issue about 3,000 separate bills per month.”

Besides these present sources of federal pressure, the bill also has devices to increase that pressure in the future. If, for example, the federal government became dissatisfied with the work of the utilization review committees, it is conceivable that the government could dictate the criteria that the committees must use. The bill sets up a vehicle for such decisions—the National Medical Review Committee, comprising nine representatives of the medical fields, including at least five doctors. “It shall be the function of the committee,” the bill says, “to study the utilization of hospital and other medical care and services . . . with a view to recommending any changes. . . .” The committee’s annual report could effect significant improvements in the program and in the way medicine is practiced.

Some informed opinion has already urged the federal government to use medicare as a club to pound some medical sense into hospitals and doctors. Dr. Frank Furstenberg, medical director of Sinai Hospital’s outpatient department in Baltimore, told the House Ways and Means Committee: “The fund itself should not simply become a vendor-paying agency, as indeed, in many instances, the Blue Cross has been. . . . Now, when we step into the program of the use of federal funds, these funds should be, it seems to us, used in such a fashion that sensitive service will be given, that there will be standards for the services, and that this should be kept under a public agency’s authority.”

The extent to which the government follows Dr. Furstenberg’s advice may depend on two factors: whether Blue Cross becomes a medical behemoth administering the program for the federal government, and whether the AMA has enough power left to resist new federal controls and pressures.

The bill encourages the Secretary of Health, Education and Welfare to contract much of the administrative work of the medicare program

Medicare: The Major Provisions

BASIC HOSPITALIZATION: COMPULSORY

Benefits

1. Up to 60 days hospitalization for each illness (patient pays \$40 deductible).
2. Post-hospital care at nursing home for 20 to 80 days (depending on length of hospitalization).
3. Out-patient diagnostic service (patient pays \$20 deductible).
4. Maximum of 100 visits by home health services.

Financing

Payroll tax of 0.35 per cent of social security wage base (\$5,600) in 1966. The rate increases to 0.80 per cent by 1987 and the wage base to \$6,600 by 1970.

MEDICAL INSURANCE: VOLUNTARY

Persons become eligible at 65 and if they wish to join must do so within three years of eligibility.

Benefits

Pays doctor’s fees, home health services, psychiatric hospital services and other miscellaneous medical and health services (patient pays annual \$50 deductible, plus 20 per cent of balance).

Financing

Those enrolled pay a premium of \$3 a month, which is matched by the federal government.

to private organizations. Blue Cross would like to do the whole job. Walter J. McEnerney, president of the Blue Cross Association, told the House Ways and Means Committee at the executive hearings this year that "the medical profession is still quite 'antsy' about . . . manipulation from the outside. This same profession, although it doesn't always welcome it, is at least fairly used to dealing with an agency such as ours. . . ." But, as Rep. Martha W. Griffiths (D., Mich.) and Dr. Furstenberg have pointed out, Blue Cross is so closely tied up with hospitals and doctors that it perhaps would not engage in sufficiently stringent regulation. Mrs. Griffiths, noting that 17 per cent of Blue Cross board members were doctors, said: "I think it would be very difficult to get into the situation where you are having doctors reviewing the prices charged by doctors and in which they are profiting. There should be someone who is far removed from any possible statement by the public that doctors are reaching into the taxpayer's pocket and getting rich." Federal pressures on American medicine would be lessened if Blue Cross acts as a buffer between the federal government and organized medicine.

The American Medical Association has so tarnished its image in the savage battle against medicare that it may find no one willing to listen to another outcry against federal encroachment. The AMA may have screeched wolf too often. At the end of the battle in the House, the AMA was even isolated from all Republicans but one on the Ways and Means Committee. In fact, the AMA performance at the final committee hearings was so childish as to defy belief. Dr. Donovan Ward, AMA president, marched in waving a clipping from the *St. Louis Globe Democrat* about a "still secret study" which showed that the medicare fund would be depleted by 1976. Later the committee discovered that this "still secret study"—based on lower taxes than the bill provided—had been prepared by the Social Security Administration and handed to an AMA representative who had asked for it. The AMA then evidently planted it with the *Globe Democrat*.

Medicare will have impact on areas other than the role of govern-

ment in medicine. One is the wealth of doctors. Despite the prolonged bad temper of the AMA, the bill's combination of compulsory hospitalization insurance and voluntary medical insurance hands benefits to doctors where it pleases them most—their pocketbooks.

Since many more people over 65 will be paying customers rather than charity patients, their improved chance for care will mean money for doctors. Every benefit provided by the bill—either in the hospitalization or medical programs—hinges on some certification by a physician. The bill will not pay for diagnostic services, hospitalization, nursing-home care or home-care visits unless a doctor has authorized them. Each authorization means a fee.

No one yet has estimated the size of the bonanza that medicare promises for America's doctors, but two figures hint at it: The total cost of health care for Americans over 65 was more than \$5 billion last year. Blue Cross, government and private insurance witnesses have told the House Ways and Means Committee that the bill surely would increase the use of hospitals by the aged; estimates vary from 10 to 40 per cent in the first years.

The bill's emphasis on nursing-home facilities should encourage the construction and staffing of these facilities. Public Health Service figures showed that the U.S. had only 325,000 acceptable nursing-home beds last year to meet a need for 840,000 beds. In short, even without the stimulation of medicare, the United States had less than 40 per cent of its needed beds. Under the bill, certain standards are set for nursing homes. Perhaps the most important: every home must have twenty-four-hour nursing services, with at least one registered nurse on duty at all times. The nursing-home association says only half the nation's 10,000 skilled nursing homes would qualify now.

Finally, the bill may encourage Americans under 65 to push for health insurance for themselves. The history of all social legislation is evidence that pressures for expansion build up quickly. During the medicare debate itself, Rep. George M. Rhodes (D., Pa.) suggested that Congress re-

duce the social security retirement age from 65 to 60.

One way of financing expanded benefits was suggested by Sen. Robert F. Kennedy (D., N.Y.) in a recent speech to the National Council on the Aging. He proposed a "limited use of general revenue financing for the [social security] system." He said it was "no longer the case" that "the worker gets out during the years of retirement what he put in during the working years." Kennedy said that "we are now



providing benefits to deserving people who properly were not asked to pay for them. But we are doing so out of payroll contributions of others." Kennedy predicted that general tax revenues will go up \$30 billion by 1970, and "I think we can certainly afford to contribute some of this to social security."

When the social security rate gets higher and Americans begin to realize they are paying a tax and not an insurance premium, there may be less compunction about using the general tax revenues to pay for health insurance and social security benefits. In fact, some use of general revenues has started already: the government, for example, will contribute \$3 a month toward every enrolled person's voluntary medical insurance.

Medicare may have its most profound impact on American society if its pressures lead to the day when the federal government uses general revenues to pay for more pensions and health insurance than it does now. Financing these through social security alone follows the principle that every man has the right to help himself. Financing these through general revenues as well recognizes that self-help alone cannot do an adequate job and that every man has the right to expect his government to help him to a pension and health insurance. That, in fact, would be a "sweeping new departure in American social legislation."

Growing Up Italian

BRUNO SANTINI. By Vasco Pratolini.
Little, Brown & Co. 313 pp. \$5.95.

Luigi Barzini

Vasco Pratolini is Italy's third greatest living novelist. (Number one, as almost everybody agrees, is Alberto Moravia. There are several potential number twos. The reader is invited to name his own. I live here.) Pratolini is successful both with the vast reading public and with fastidious and severe literary critics. His books reach the best-seller list, are translated into the principal languages and often enough made into movies. At the same time each new one is welcomed by the intelligentsia; his themes are dissected and debated in obscure literary journals, and technical essays are written on his language and style. One problem found in each of his novels haunts many Italians in their 40s and 50s: how can the same man have been an honest, brave, bona fide Fascist and be now an honest, brave, bona fide Communist?

Pratolini's latest novel published in the United States, *Bruno Santini*, translated by Raymond Rosenthal, is the story of a boy growing up in a Florence industrial suburb. His father died in the war, a volunteer in a Fascist unit. The pretty widow, Ivana, worked as a cashier in a café and later in a moving picture theatre to support her son. Ivana had a few affairs, which she naturally concealed from her son, but was never the mistress of Millo, a bachelor, her dead husband's dearest friend, and like him, a metal worker, a Resistance hero and a veteran Communist. As a consolation, Millo, who always loved her hopelessly, took care of the orphan boy as if he were his own nephew.

Millo taught Bruno his love for metal-working machinery and the Communist Party. The boy talks about lathes—the Milwaukee, Cincinnati or Genevoise automatic types—as other boys talk about racing cars, and believes the Communist Party is the ultimate bulwark of justice and man's liberty. But the day comes when Bruno grows up, becomes suspicious of his mother, and jealous of Millo;

he beats his father's old friend and unjustly throws him out of the house. At about the same time, Bruno experiments with sex (by making love to refugee Greek girls from a camp), tries to get a job in the big factory, and acquires a few friends.

The choice of these friends allows Pratolini to review the moods in contemporary Italian youths. One of them is busy making money: he renovated his father's peasant *trattoria* and made it into a chic roadhouse. Another is Joe, a mulatto, the son of an American Negro GI and a Neapolitan streetwalker who followed her lover to Florence. The GI died fighting and is buried in a nearby cemetery which his son visits regularly, worshiping his memory. Joe is deeply religious and wants to become a priest. Then there is Benito, named by his father, an old Fascist, after the late dictator. Bruno, who describes himself as a "free Communist," discovers that he dreams of the same things as Benito. Both seem to be against "capitalists, priests and traitors, against the rich, the masters, those who own automobiles while we do not own one, against those who do nothing and go to the sea in the summer." They are both for some sort of dictatorship to set things right. They differ only on the color of the shirts that would be worn by the dictator's militia and the official justifications required for such a regime.

Finally Bruno meets his girl. Lori is from a working-class family, slim, almost fragile, pretty, chic. In fact, she reminds Bruno of his favorite movie star, Eva Marie Saint. They fall in love, go for rides in the barren winter landscape on his new motorcycle, speak probingly and at great length about themselves, their love, the world, their hopes, and life in general. They eventually sleep together in an empty and unheated room Bruno and his friends keep for their modest orgies. Lori, like the heroines of many 19th-century novels, has weak lungs. Nevertheless, like the same heroines, she disregards warnings and burns the candle at both ends. The motorcycle rides in the cold air, the frequent disrobing in the unheated room, and the incessant

cigarette smoking eventually bring her down. She falls sick and dies movingly in a hospital room. The fact that the situation is a traditionally romantic one shows Pratolini's fearless ability as a novelist. He narrates the story admirably, as if he were the first to think of it.

Bruno Santini sold like most of Pratolini's previous novels in Italy. It was reprinted a number of times within a few weeks. The reasons for its success are, as usual, twofold. On the level of popular fiction, Pratolini can scarcely be beaten. Events follow one another smoothly; characters live, feel, converse, suffer, make love, and often die convincingly before the reader's eyes; the scenery—Tuscan winter hills, the wild seashore off-season, the gloomy working-class quarters of Florence—is swiftly sketched with a few master strokes. The reader is mesmerized, whether he gets the message or not, and does not stop reading until he reaches the final paragraph. Curiously enough (this has to be mentioned in any analysis of the reasons for Pratolini's popular success), there are echoes of forgotten writers he has never read and probably does not know exist, writers popular among ladies.

His principal characters are all unusually handsome and as a rule they dress tastefully. Lori appears wearing "a mauve, flared overcoat, a scarf around her neck, a faint touch of red on her lips, her hair cut like mine (Bruno's) but gleaming with natural red and gold." Later, on a trip to the sea, she is described as "elegant and casual, wearing a light woollen pale green dress with short sleeves, that clung to her breasts and hips, and a purple scarf around her neck." The young people lard their conversation with American slang, play American jazz records (whose lyrics they quote in the original), frequent night clubs with exotic names, like Florence Beach or Chez Moi, where they drink whisky or *negroni* cocktails.

All this is as startling as if American workers from the slums were portrayed singing the latest French songs and drinking Aquavit from Scandinavia or Grappa from Italy. The Florentine proletarians I know (admittedly belonging to the older generation and mostly seen from the outside) do not know one word of English, and lard their pungent Flor-

Luigi Barzini is the author of *The Italians* (Atheneum).

Thinking About Her Poems Again

She has come up from the basement and is out of breath.

Her left hand is twisting the right cuff of my coat
As we stand swaying in awkward ceremony.

She stands on tip-toe and gasps — softly —

Because she is out of breath but has made up her mind
To tell me something after all. I can scarcely hear her,
But I hear — the words chosen so frugally,
As for an urgent cable that must go around the world.

Emily Dickinson, Emily, you have made of us
A legion of individuals — yes, of lovers!
So, I've said it, and we think we stand a chance,
Each man for himself. I sigh only for myself.

You have seen this in my eyes before hurrying to the attic.

Grand go the years — wild nights — wild years —

Leonard Unger

entine patois not with American words but with the most picturesque curses in Western Europe; they drink only the very best Tuscan wines, and frequent places called Gigetto or Il Troia. If one trusts Pratolini, these young Communists are becoming cosmopolitan bourgeois with a discriminating taste for clothes, music and bright conversation which is definitely Western. When one of the characters dreams of going somewhere and mentions a list of places at random, the American or Western names come first, the Russian and Chinese as an afterthought. These, for instance, are the most desirable resorts, listed by Bruno: "Saint Tropez, Santa Monica, Sochi." Why do they consider America a halfway station to the Soviet paradise for workers?

Pratolini, of course, is not cheating. His characters at times seem to behave like country-club characters in a serial for American provincial ladies, possibly because the young working people of Florence do behave like that at times, or like to think of themselves as behaving like that, which comes to the same thing. Pratolini knows what he is talking about. He was born in a Florentine working-class family, worked as a printer in his youth, and educated himself in his spare time. His interpretation of the people he knows so well is one of the reasons for his success, both among the avid readers and the exacting critics. More Italians read today than ever did before, and they are increasingly interested in the mores of the working class; many new readers belong to (or come from) the working class; others from the frightened bourgeoisie want to know what is possibly in store for them. Many Italian novels are therefore dedicated to the prob-

lems, habits and psychology of the workers, but few writers manage to sound authoritative. Pratolini does. He is the best of them.

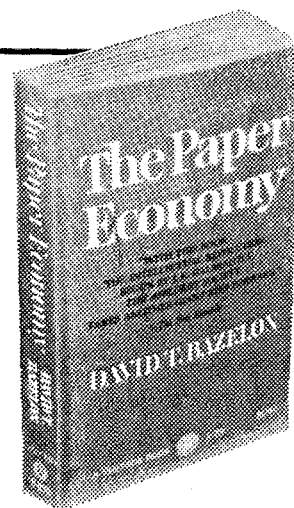
Consider his use of language: Italian has been for centuries a musty and bookish Mandarin. People spoke it seldom and only on formal occasion. At home and with their friends, they preferred the local patois which vividly expressed their feelings and best described their familiar world. (It is still almost impossible to write witty comedy dialogue in Italian or translate it from French or English.) Contemporary authors feel caged within these dead literary forms, and are trying to escape. They experiment with new words; graft expressions borrowed from provincial dialects and street talk of the common people into the literary language. Pratolini, again, has a natural advantage over his competitors. He not only belongs to the people but his native *Fiorentino* is the wittiest and richest of all patois. He uses it as skillfully as a jeweler making a finely chiseled *oeuvre d'art* from base metal.

Pratolini, like the people for whom he is the spokesman, remains difficult to label. He is a Communist like one Italian out of four, but not a party-line Communist. He was a Fascist in his youth. The problem is debated in *Bruno Santini*, as it was in his other books, but he is not the only Italian of his generation who is bothered by it. The same theme occurs in another successful book, the autobiography of Davide Lajolo, titled *Il Voltagabbana*, or *The Turncoat*. Lajolo was the son of Piedmontese peasants who rose in the Fascist party organization and volunteered for the Spanish war on Franco's side, but founded and led partisan formations

in the last years of the war against the Fascists and the Nazis. He later was named editor in chief of *L'Unità*, the party organ, and elected to Parliament.

Men like Lajolo and Pratolini were inspired to join both parties by roughly the same ideals — love and compassion for the common people, the desire to free them from poverty, injustice and oppression, and hatred for the powerful and rich. Both times they thought all this could be accomplished by an enthusiastic popular movement. It should not be forgotten that among the founders of fascism were many dissatisfied left-wing young men, and that Mussolini himself had been a revolutionary Socialist.

Today, Bruno Santini (like many of Pratolini's generation) has no specific remedy to suggest. But he still wants to destroy things as they are and vaguely dreams of a world run by workers and "technicians" according to plans. One does not expect more from him, because a novel is not a political tract. The novelist is supposed to express the confused yearnings and the restlessness of his generation, and this Pratolini continues to do admirably.



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May 3, 1965

Outgrowing Germany

THE CLOWN. By Heinrich Böll. Translated from the German by Leila Vennewitz. McGraw-Hill Book Co. 247 pp. \$5.

Stephen Koch

Americans read new German fiction, if at all, in order to investigate the improbable survival of a culture. The great inheritance of prewar German literature—its formulation of the relation of the artist to the bourgeoisie, its discoveries in irony, the grotesque, subjectivism—have passed on as common property; property we do not wholly trust in German hands. Beyond what we most want to hear—the cries of *mea culpa*, of abjection and surrender—we are not sure what to expect from German writing, or what we want. There ought to be a moral preoccupation—how could there not be?—and considerable self-criticism, even among the young—for is there not such a thing as a continuing national temperament?

The fact is that while we do not want the Germans to disregard or transcend their history, we do not see how they can possibly produce anything worth while making use of it. Germans, we feel, have fatally destroyed, once and for all, every foothold for the position of moral superiority from which we expect a novelist of society to speak. With reservations, we can accept their transcriptions of social adjustment and self-doubt. But what we secretly want is a work of suicidal humiliation.

This, at any rate, was the common attitude until a few years ago, when certain late products of the German literary "renaissance" mainly brought about by what is known as the "Group 47" took hold in England and America. People now give respectful attention to Günter Grass and Uwe Johnson, but the older members of the Group, men old enough to have been adults during the war—Heinrich Böll, Hans Werner Richter, Alfred Andersch—have been largely ignored. Max Frisch, a Swiss, whose novels are among the best of the older generation, created a certain stir with a transparent, tricky play, *Andorra*, by virtue of making it the most direct treatment of anti-Semitism the group has turned out. Beyond this, there are several poets—Hans Magnus Enzensberger, Ilse Aichlinger, Ingeborg Bach-

man, Paul Celan—who, despite translations, remain trapped behind the wall of language.

Plainly, the self-conscious organization of the Group—there are even yearly conventions—results from the need for something like a salvaging crew. In 1945, German culture, bereft through murder or emigration of its best minds, despised by nearly everyone, and threatened with the possibility that its own former greatness had contributed to the disaster, must have seemed, even to Germans, irredeemable. A nation that had become the most violently anti-intellectual in history could not be expected to spontaneously sustain writers of merit; they had to be extracted from rubble, intravenously nourished, slowly brought to consciousness, and taught all over again their name, their home, how to speak.

The label "Group" is somewhat deceptive. The older members are, it is true, monotonously alike. All of them highly derivative, they make use of an imported tradition—the international literary "realism" variously patched up out of Hemingway, Faulkner and Camus, that was exhausted even before they took it up as their new voice. The newer writers still are heavily dependent on this "realism"—Uwe Johnson has at last made clear to me the European fascination with Faulkner—but they apply the old conventions far more skillfully, nimbly, than do their older instructors. Further, Günter Grass—easily the most fertile imagination within the Group—has found in his shambling whimsicality an idiom of his own. And Peter Weiss, whose *Marat/Sade* has unfortunately not yet appeared in America, has, I understand, made a complete departure.

Yet, so far this commitment to "realism" has been a decisive common trait. German letters before the war could boast of having produced the most radical innovator and the loftiest traditionalist of the century: Kafka and Mann. Since the war, German writers—and that virtually means the Group—have experimented with the conservative, and, at worst, trifled with the mediocre. The reason is more complex than simply the strategy of a slow recovery; it is peculiarly German in nature, and ultimately political.

There was, first, the need to explore accurately the German character and personality, especially with a view to-

ward establishing what one of their mentors called a "separate peace." Some critics of American literature have regarded the tendency to mythicize, to deal with experience in terms of formal, definitive metaphors, as attempts to "escape from history." In Germany, the tendency has been just the reverse; the mythic imagination has always been preoccupied with history. As the poet Enzensberger has pointed out, the peculiarly German, infectious sense of radical involvement in a national (or substitute: class, racial, religious) ethos—including a national ethos of guilt, which most of the Group rejects—is the shredded, neurotic hangover from the old notions of autonomous, apocalyptic, mythicized history that led to totalitarianism and statism. Germans have felt themselves—in Hannah Arendt's phrase—the "fools of history" too long; in reaction, the Group wants to liberate themselves with the truth through a commitment to literary realism.

This has not been very valuable, artistically, but it is entirely admirable. There is, however, a second, less admirable motive. In Germany, the nihilism that gave birth to some of the most impressive achievements of modern German writing had—like the romanticism it had radically qualified—far more intensely dramatic political and moral implications than elsewhere. By the turn of the century, the literary view of social morality had begun to emphasize fatally the Satanic in a "modernist" temperament, thinking of itself as anti-humanistic, anti-rational, anti-individualistic—the bearer of what Gottfried Benn, who was briefly a Nazi, called a "primal vision." These tendencies, that elsewhere became a qualified apolitical sensibility, lent themselves in Germany to a vicious amoral politics. These writers—mainly expressionists—failed to understand that even while diddling with notions of "primal visions," "blood" and weird aesthetics of technology, they had retained intact the old distinctions of romanticism: the poet as against the stupid masses, the "free" as against conformist morality, the lyric as against the rational.

They failed to acknowledge the humanism in their "primal visions" and mistook a mere release from social morality for nihilism which promised a mastery of the self. But the "liberated" imagination they celebrated emerged as vicious. The results were disastrous, and their effects are still being felt. To be blunt, many of the Group have reacted by mistrust-

Stephen Koch teaches at The City College of New York.

ing, even rejecting, the imagination itself. They replace its strategies with a nervously circumscribed realism which lacks even the strength of its own convictions. Maddeningly, they still portray the bearer of imagination (when they do) within the treacherous old categories — characteristically set apart as some ironic *poeta dolorosus* — and they portray him with equally maddening timidity.

An example of this timidity — perhaps the example — is Heinrich Böll's *The Clown*. I don't much like this novel, but I think it is probably Böll's best. His attempts to apply Hemingway to standard German themes in his early books seem to me bad to the point of being grotesque, and his experiment with Faulknerian stream-of-consciousness in *Billiards at Half-Past Nine*, at best unsuccessful. But there is a relatively harmonious fusion of theme and idiom in *The Clown*, and for this reason it is useful as a demonstration of the outer limits of Böll's method.

Hans Schnier is a real clown — an Emmet Kelly of real life — sinking into doldrums of professional and personal ineptitude because he has been abandoned by the woman for whom he left his wealthy family. Marie had sustained him as he traveled around Germany, performing little social satires and Chaplin imitations for conventions and vaudeville. Their trouble developed because of her conversion to Catholicism, which he finds intolerable, less because of his own atheism than because she has surrounded herself with a group of liberal Catholics whose dishonest chatter about poverty, democracy, ethos and the Son of God appalls him.

I don't know whether there are people who use designs by Picasso or Klee for embroidering tablecloths. It seemed to me that evening as if these progressive Catholics were busy crotcheting themselves loin-cloths out of Thomas Aquinas, St. Francis of Assisi, Bonaventura and Pope Leo XIII, loin-cloths which of course failed to cover their nakedness for — apart from me — there was no one there who wasn't earning at least fifteen hundred marks a month.

Thus, Marie finds salvation by accepting — not disingenuously — the hypocrisy the clown would attack in satire; she marries a prominent Catholic layman, goes to Rome to meet the Pope, and proposes to become the "First Lady of German Catholicism." Broke, nearly ruined by vicious re-

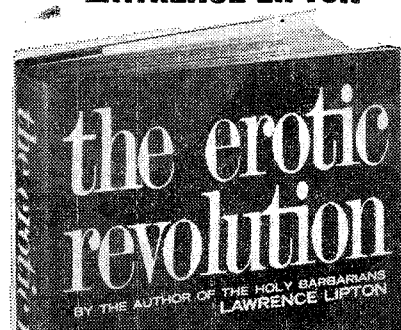
views, ill, drinking too much, the clown holes up in Bonn, and, in the body of the book, bitterly ruminates, telephoning all his friends and relatives to alienate them with aggressive Dostoevskian abjection. These assaults are at once social satires, self-revelations and cries for help. And when the last one fails (his Catholic brother Leo will not leave his seminary after hours for fear of an "exhortation") the clown puts on his make-up, walks to the railway station, and crouches in the gutter — where he has always dreamed of dying — to sing for pennies.

*Catholic politics in Bonn
Are no concern of poor Pope John
Let them holler, let them go
Eeny, meeny, miny, mo.*

Böll has inlaid the standard German romantic theme of the poet's pathos, futility, need for love, emasculation, into the texture of the sociological-critical search for identity we have come to expect from American fiction. The theme may be German — there are countless predecessors; Wedekind was himself a night-club entertainer, and he made many of his "poets" the bitterest of fools — but aside from the criticism of the Nazis, this novel could have been written next door. Indeed, I was reminded throughout as much of Saul Bellow's *Herzog*, which *The Clown* astonishingly resembles, as by any specifically German work. In both, cuckoldry brings about a confrontation with wobbling identity, ineptitude, the past, middle age, dependence upon a confused, dishonest society, professional and personal failure.

The clown, Hans Schnier, and Herzog (in German: *Herz*, heart; *Herzog*, duke) are both men with lofty roles — poet and intellectual — who have never been able to fully assume these roles and who are finally absurdly humiliated within them while the frauds — Gersbach, in Bellow's novel and the "prominent Catholic layman" in Böll's — win the game. Both books pessimistically view the involvement of their characters in what Bellow lovingly calls the "quotidian," and record their struggles with the devices of the isolated — gnawing, morbid letters and telephone calls. Yet this same "quotidian" is their only true place, their only possible source of identity, and it offers as a bonus, ample opportunities for the author's social criticism. Finally, although *Herzog* is written mainly in the third person and *The Clown* in the first, both the books are obviously intended as an ambiguous but redemptive gesture

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within this pessimism. All that truly separates the two novels is a difference in intended response: Bellow seeks the pathos of irony, while Böll—in the German manner—is after the irony of pathos.

It is odd that the member of the Group most temperamentally American should be the one who remains in relative obscurity. He gives us what we presumably want, but, in the end, we do not want it. The reason is somewhat marginal to literature. Books like *The Clown* do not confirm prior impressions of German social reality. We have something like the suicidal despair that we expected before Grass and the rest appeared; but the society where it is found, though German, looks rather like our own—humiliation derives not from guilt, but loss. We would like to believe that German hypocrisy is the hypocrisy of evil rather than of emptiness.

Of course, so far as the novel is concerned, it does not matter whether the conventional American view, or Böll's, seems accurate. The best place to look for accurate answers is factual politics, real sociology, or personal contacts. What remains for this kind of fiction is the sensibility of a single man—the clown or Herzog—as he encounters this "society." Böll and Bellow snare their characters within the "quotidian"—making them bumbling, inept, suffering, nervous, fussy, hung-up, *schlemiels*, clowns—while consciously rejecting as alien, immoral,

inaccessible or just plain wrong, other possibilities for the imaginative man, though they are themselves quite aware of these possibilities, and make their heroes poets or intellectuals who are equally aware of them.

It is strange, though perhaps inevitable, that this method—the conventionalism of our time, an international conventionalism without an international audience—should purport to be a fiction of "identity" while it almost shamelessly employs standard, even antiquated literary types. It would not take long to whip up a little lecture on Clowns, Fools, and *Schlemiels* in Literature: Their Function Within the Ironic. I am aware of course that the claim is to somehow escape or transcend these stereotypes. But it seems equally clear that while men like Böll persist in seeing man's experience within these creaking frameworks, the stereotypes will none-

theless be embraced. We have been speaking here of the denial of freedom to those who, in the traditional romantic schema, are in privileged positions: poets and intellectuals. This seems to me unfortunate, because I believe the old notions of these privileges are indeed archaic. It may well be that the romantic imagination has finally discredited itself—with the Nazis contributing more than their share; certainly in politics it is wholly to be mistrusted. But the fact remains that the authors of these moral fictions have retained the old traditions; Böll's clown and Herzog (and how many others!) remain Quester Heroes—frustrated, comically denied, compromised, to be sure; blinded and afraid of their goal, but little romantic nihilists, just the same. "Bereft of all truth," Nietzsche wrote, "I am a fool, a poet." If we must have this point of view, the two ought to go together.

Surviving Ireland

THE FERRET FANCIER. By Anthony C. West. Simon & Schuster. 256 pp. \$4.95.

Arno Karlen

Anthony C. West hasn't won wide success in America. First, he is commonly confused with the Anthony West whose work appears in *The New Yorker*. Second, his volumes of fiction have not been publicized here. And then, his style and subjects are sometimes dismissed by the hip—the fake knowing, the fake superior—as old-fashioned. Perhaps the release of his new novel, *The Ferret Fancier*, by his new American publisher will bring him the appreciation here he has already won in England.

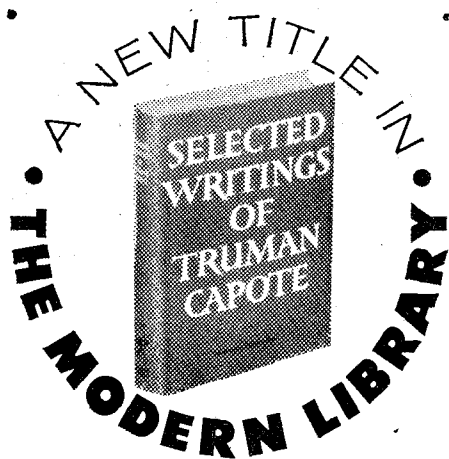
West was born in 1910 in a village in County Down, in northern Ireland. He spent his first twenty years there, and then emigrated to America. After a year in depression-struck New York, he took off across the United States and Canada, making his way to the Pacific Northwest as a farm laborer. When the war came, he did not return to neutral Ireland, but went to England to sign up with the R.A.F., and served as a navigator in a lead bomber during raids over Germany. When the war

was over, West married and settled down to farm and write on Anglesey Island, just off the coast of North Wales, facing across the Irish Sea toward the homeland whose narrowness and bigotry kept him from returning. Now he lives on the mainland of North Wales, in a little quarrying village called Rhiwlas, supporting himself and his family of thirteen by writing stories and novels.

West's work first appeared here in the fifties, when *Esquire* printed several of his stories, including a brilliant long tale set on a farm in Canada, *The Monocrats*. These and others were gathered in a volume called *River's End* in 1958 (Obolensky). In 1959, the novel *The Native Moment* appeared, and in 1962, another novel, *Rebel to Judgment* (both Obolensky). And now *The Ferret Fancier*.

Most of these works deal with the childhood and early manhood of someone very like West himself—a Protestant farm boy raised in mixed Catholic-Protestant Irish countryside; isolated from a puzzled, angry father, drawn to and then disappointed in a sickly mother who aspired to gentility and learning; trapped in the cruelty, the narrowness, of village and farm; fighting for manhood and an independent vision of things; running away; working his way across Canada and the States from farm to farm, searching for peace with himself, love of self and of woman.

Arno Karlen has written criticism, translated from French, and published a book of fiction: *White Apples* (Lippincott).



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West's past is his capital; he does not keep turning back to his early life with sentimentality, or in desperate flight, but as some artists turn to women, or to politics—as objects in which to see a bit of themselves revealed, and so, by knowing themselves, to know more than themselves. West's past is a microcosm in which he seeks a pattern for the world and himself in it.

The Ferret Fancier is largely given to describing an adolescent boy named Simon Green and the village and villagers about him. Without any patina of "tradition" or "local color," West reveals the smug bigotry of both Protestant and Catholic: their iron condemnation of lust though each mind is haunted by it; the servile poor gouged by the lordly landowners; a land where love is given to God alone.

With shrewdness, with cool, treasured anger, West presents characters such as Rainey, the schoolteacher, who waits and watches for sin as though it were manna:

George Edward Marcus Bastard Rainey: just as he smelled and tasted: chalk, ink, pencil parings, stale breath off the wet swamps of his yellow false teeth, sweat . . . digging the wax out of his big hairy-holed ears and rolling it into pickles between finger and thumb, turning his false teeth over inside his mouth and licking the bits off the backs of them. . . . Lady Corran still called infrequently at the school and told them about God and their betters in a lazy exciting icicle of a voice, filling the stale room with her wild sweet perfume, Rainey bowing and scraping round her like a dancing master. . . . Sometimes she sat on Rainey's high stool, her back to the wall, her long heels hooked in a rung and the boys in the front desk jammed themselves into a tight lump to try and see up her noble legs.

And Thubby, the club-footed, club-spirited school troublemaker:

Thubby . . . had an uncanny dead kind of memory. . . . Simon was always a little scared of him and his ability to make everything as material as a latch on a door. He was honest but truthless, and his ruthless curiosity and selfish detached indifference to everything save physical pleasure and pain allowed him to trot at the stirrup of any hunt, while never being involved.

The villagers seem creatures imagined by Rodin at his most tragic moment: stubbornly, and perhaps vainly, trying to rise from the mud in which they were generated, despising it and unable to detach them-

selves. The coupling of man and beast are interrupted by the thought of God (one of the book's funniest scenes shows the schoolmaster's wife hysterically trying to prevent the mating of farm animals). And, of course, thoughts of God are waylaid by thought of coupling. The prim speeches of teacher and priest and gossip are accompanied by a smell of dung and turf, the sound of wind and running water. The split is in Simon Green, too. Unable to find his own voice in the company of the villagers, he flees to solitude in the woods and fields, yet succeeds little more in finding his voice in the sounds of water and wind.

The book contains magnificent natural descriptions; realistic writing of the finest kind; long philosophical passages; pathos and wit. West's language leaps in mid-sentence from literary-lyrical to back-yard Irish. The fusing force is the poetic voltage of his alliterations and the long, swinging rhythms of six- and eight-line sentences that spin the mind to where descriptions of woods, of feelings, meditations, dialogue, all combine to give the effect of awe before a dizzying confrontation—the struggle to be human amid the rest of nature.

Simon Green finally makes his way to a deep knowledge of himself and the world through his relationship with a pet ferret called Jill, which he uses to hunt out and destroy the rats whose burrows honeycomb his family's farm. The rats come to stand in his mind for everything slinking, vicious and despicable in the village; the ferret comes to symbolize the combative impulse he feels against it, potentially self-destroying, potentially self-creative.

"Jill had this feral, reptilian, transcendent courage, and wasn't scared of anything on two or ten legs. Although, even then, he could see dimly that such a destitution of fear could be a terrible curse and a true misfortune; a kind of helpless criminality. . . .

"He had done about everything a boy could well do, devouring if not digesting all local life and ways, hearing all hearsays and believing them for gospel, never taking anything with salt, emptying each season as it surged over the skies, watching people drawing themselves on air while hearing the breeze coming that would blow them away. Baptisms, births, weddings, deaths, wakes, funerals, harvests and Christmas car-

ols, Easter matins and autumnal evensongs. Seeing everything and understanding nothing—reading the names on everything like padlocks on shed doors—names strung together to make a rope of sense which, somehow, was only ever nonsense."

Finally, in fear of his own rebelliousness, he lets Jill die; soon after, in shame at his cowardice, he rebels at the village school. There now begins his passage toward manhood which

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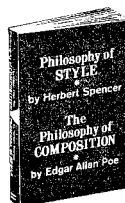
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is the kernel West seems to have been seeking throughout the book.

"Years later, Simon remembered that day exactly and knew it for a tolerable watershed after a long bruising crawl up a rocky hill, another valley and another crest ahead, then more valleys and more crests, until the last valley, or the last crest was climbed, for death is a height, not a hollow."

The book's failings are the minor ones to be expected from a self-formed and rather isolated writer. The symbolism of ferret and rats sometimes becomes a little heavy. The philosophical passages occasionally turn turgid and vague, and what is intended for direct simplicity may become cliché. West is, in fact, part modern intellectual, part tongue-gifted villager, part mystic, who gives first care to his own soul's progress. His books seem to have germinated not in reading and discussion but during the nights in the farm sheds in which he slept as a young, wandering laborer. The influences are few and strong,

the failures a bit naive and obvious, the strengths as solid as stone; there is the moving directness and urgency of a man who started late trying to extend his vision and record what it takes in. He is not at all a primitive, a literary Rousseau; but he is what was once called an original.

West has not yet written a great book, but several fine ones. His successes are moving, his occasional failures as honest as a loaf that didn't come quite right—saltless or heavy, perhaps, but at least warm and free of intent to defraud. You are never short-weighted. It is a rare novel now that fills the appetite instead of merely arousing it.

West once wrote, "If you can write *beyond* exhaustion, you'll say something you'd never even thought about." This is what West, at his best, has done: butted continually against the land and people he knows most—knows in the Biblical sense, as one knows a lover or a precious enemy—until he wins through to a poetic, a prophetic, voice.

Practice and Malpractice

(Continued from page 467)

Malpractice suits cover a variety of real or imagined grievances, running all the way from claims by patients for injuries sustained in falls from hospital beds or in doctors' offices to cases of glaring medical laxity. Some of the actions are nuisance suits, brought on flimsy grounds in the hope of quick settlements. But there is little question that many of them arise legitimately from serious instances of medical negligence or carelessness.

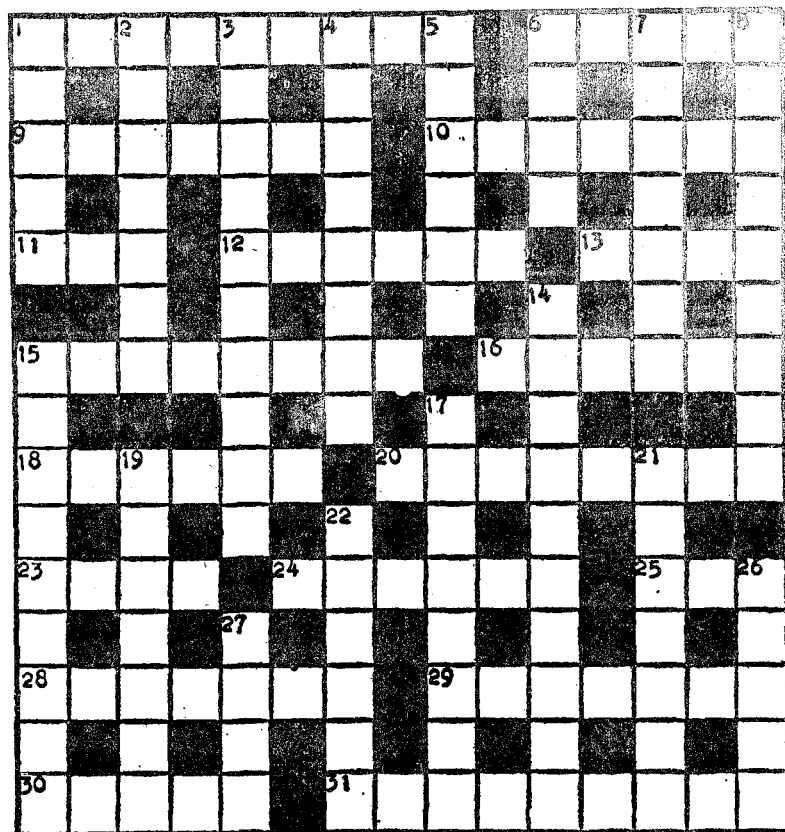
The growing estrangement of doctors and patients has undoubtedly been an important factor in the situation. The idea of malpractice litigation hardly ever occurs to the patient who is satisfied with the care he is getting and who enjoys a warm and mature relationship with his doctor. But as the family doctor has increasingly given way to the busy specialist who treats the patient impersonally, the bond that once made a lawsuit against a physician unthinkable has been steadily weakened. The act of suing a doctor is often the culmination of prolonged friction and anger, sometimes directed not against a particular physician but against the medical profession in general.

Often patients are not recompensed for the harm done them because of the traditional conspiracy of silence among doctors. Far from uncommon are the cases in which physicians privately agree that certain doctors are criminally negligent, but flatly refuse to take the stand against them. Regardless of how flagrant the case may be, it is almost impossible to get one doctor to testify against another. Covering up one another's mistakes, either by refusing to appear in court against a negligent colleague or by actual lying on the witness stand, seems to be the unwritten rule, even though all physicians are pledged by their code of ethics to expose the misdeeds of their professional fellows.

Malpractice suits are occasionally little more than attempts to blackmail honest and fully qualified practitioners, but the primary causes of such litigation are medical incompetence and carelessness. The basic trouble, as one attorney who has handled a large number of malpractice cases has said, is that "many doctors today run their patients through like a sausage factory."

Crossword Puzzle No. 1104

By FRANK W. LEWIS



ACROSS:

- 1 Certainly not a heavy cruiser, though its beam may be fairly broad. (9)
- 6 See 9 across
- 9, 6 across, 25, 17 down and 28 Implying a quick splice isn't likely to bind successfully. (5,2,5,3,6,2,7)
- 10 Proving the French, in youth, are like some wines ideally. (7)
- 11 See 3 down
- 12 Monkey, being one responsible for the pack. (6)
- 13 Offers some touch in the game, though the 11 type might easily identify one. (4)
- 15 If you own your own, you might have company. (8)
- 16 In order to have one's self precede? (6)
- 18 Could broken hinges give off such inhuman sounds? (6)
- 20 Try a dozen bottles or so, and it might establish a precedent. (4,4)
- 23 This at the top of the picture? (Enough space implied!) (4)
- 24 See 30
- 25 and 28 See 9
- 29 There might be a drink in it which is rather brown and sort of dark. (7)
- 30 and 24 Buying blind? You'll get it this. (5,6)
- 31 Any one from Burke's Peerage—or just the first one. (5,4)

DOWN:

- 1 Halt, or so made. (5)
- 2 Puts the car away when the storm

is in vapor form. (7)

- 3 and 11 Make a 20 with one's best friend, reputedly. (3,2,2,3,3)
- 4 Animal not quite all taken by the devil, if what some people say be true. (8)
- 5 Ship a bundle, possibly. (6)
- 6 Undoubtedly cold greeting implied! (4)
- 7 Silver? Keep it in good health—and save! (7)
- 8 Nelson's voice quality was light, as might be remembered in a main song. (9)
- 14 Self-restraint of Africa and Asia, by the sound of it. (10)
- 15 Be inclined to do what a craps shooter does—you'll make wads of money! (9)
- 17 See 9 across
- 19 Evening out, perhaps. (7)
- 21 Scene of a novel meteorite shower? (7)
- 22 Put in the answer here. (6)
- 26 What John Dawkins did in the city? (5)
- 27 Only fair! (4)

SOLUTION TO PUZZLE NO. 1103

ACROSS: 1 and 11 Practice makes perfect; 10 Up-ended; 12 Scarlet; 13 Riveter; 14 Outlaws; 15 Reserve; 16 Overeat; 20 Curacao; 23 Festive; 24 Testate; 25 Charted; 26 Animagist; 27 Dead reckoning. DOWN: 2 Reenact; 3 Cedula; 4 Indites; 5 Emperor; 6 Arrives; 7 Ejector; 8 Runs for office; 9 Starve to death; 17 Ensnare; 18 Evicted; 19 Treadle; 20 Cutback; 21 Russian; 22 Clarion.

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